PRINTED: 01/31/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL'	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R
NAME OF PI	ROVIDER OR SUPPLIER				ITY, STATE, ZIP CODE	09/	30/2021
PARKVIEV	V POST-ACUTE AND RE	HABILITATION CENTER		200 NURSING HOME PIKEVILLE, KY 41			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH C	IDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B EFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS		{F 0	00}			
ARORATORY	in conjunction with an investigating Complai KY00033745, KY0003 KY00034032 beginning concluded on 06/19/2 KY00033911, KY0003 KY00034031, and KY to be substantiated widentified. Deficient put the highest Scope and "F" level. Census: 10 After supervisory revince recipication Survey investigating KY0003 KY00034030, KY0003 KY00034030, KY00034238, KY0003 KY00034238, KY0003 KY00034238, KY0003 KY00034238, KY0003 KY00034032, KY0003 KY00034032, KY0003 KY00034032, KY0003 KY00034032, KY000340	nt KY00033911, 34030, KY00034031, and ng on 06/15/2021 and 021. Complaint 33745, KY00034030, 00034032 were determined ith deficient practice ractice was identified with d Severity identified at an 9. ew, the Standard v and Abbreviated Surveys 3911, KY00033745, 34031, and KY00034032 /27/2021, in conjunction with 173, KY00034237, 34299, KY00034400, and 134299 and KY00034404 . KY00033911, 34030, KY00034031, 34173, KY00034237, 34400 were substantiated lirdy was identified, on determined to exist, R 483.10 Resident Rights 12 Freedom from Abuse 12 Comprehensive le Plans (F655), 42 CFR le (F684), and 42 CFR rol (F880). The facility was late Jeopardy on lediate Jeopardy is ongoing.					
	cally Signed	OF THE REPRESENTATIVE 3 SIGNATURE			TITLE		(X6) DATE 11/04/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation

11/04/2021

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUI A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R
NAME OF P	ROVIDER OR SUPPLIER			_	FREET ADDRESS, CITY, STATE, ZIP CODE	09	/30/2021
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER			00 NURSING HOME LANE IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	Resident #82. Resided of exposing himself/he other residents, wand resident's rooms, and abusive to other residimplement effective in Resident #82 from ab Resident #82's behave resident-to-resident all Resident #82 grabbed skin tear; On 06/04/20 Resident #64's wrist a 06/30/2021, Resident wrist because Resident wrist because Resident wrist because Resident shoe causing a large I upper arm; and, On 07 Resident #64 on the learnesidents and staff reviand #322 were afraid with Resident #86 on resident was afraid to #82 still came in his/he taken no action to profit for Resident #321 and to ensure the residents care in accordance with practice. On the morn approximately 7:30 AM #321's blood glucose I 67) mg/dL (milligrams 70 mg/dL to 110 mg/dI the resident's insulin in the resident an oral hy	sident #322 from abuse of ent #82 displayed behaviors erself numerous times to ered in/out of other was verbally/physically ents. The facility failed to terventions to prevent using other residents. iors resulted in the following buse: On 05/18/2021, if Resident #322 causing a 021, Resident #82 grabbed and would not let go; On #317 held Resident #82's not #82 wandered into lid not leave; On #82 hit Resident #86 with a bruise to the resident's 7/31/2021, Resident #82 hit left wrist. Interviews with realed Residents #64, #86 of Resident #82. Interview 07/27/2021 revealed the sleep because Resident er room and the facility had tect the resident. Resident #323 and failed is received treatment and the professional standards of thing of 07/18/2021, at M, staff obtained Resident level, which was sixty-seven per deciliter) (normal range L). Although the nurse held regolycemic medication.	{F (000}			
	The nurse stated after	breakfast she re-checked					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		185256	B. WING			R
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE		1	STREET ADDRESS, CITY, STATE, ZIP (200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE	09/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	100000000000000000000000000000000000000	TION SHOULD BE THE APPROPRIA	E COMPLETION DATE
{F 000}	one hundred thirty-nin there was no evidence monitor the resident oblood glucose level, u afternoon. Sometime Resident #1 unrespor level of forty (40) mg/c revealed they adminis injectable and oral gluregained consciousned documented evidence the resident's blood gl approximately 12:30 A Resident #321 was fo clammy. Interviews at the resident's blood gl mg/dL. Staff again ad injectable glucagon ar #321 remained unrespectable glucagon ar #321	lucose level, which was then lee (139) mg/dL. However, lee the staff continued to live re-check the resident's intil sometime later that lafter 3:00 PM, staff found lisive with a blood glucose lidL. Interviews with staff litered Resident #321 both, licose, and the resident liss. However, there was no lee staff continued to monitor lucose level, until lid on 07/19/2021, when lund unresponsive and lucose was thirty-two (32) liministered the resident lucose was thirty-two (32) liministered the resident lucose was thirty-two (32) liministered the resident lucose was developed lucose and develop	{F 0	000}		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		185256	B. WNG				R
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
{F 000}	and was diagnosed winsufficiency, and left versus atelectasis (lur Further, the facility fair maintain an infection program to properly program to though, the facility propositive, there was not determine which residinfected staff in an efficient properly properly properly properly properly properly program to the facility failed to im COVID-19 per the facility of the staff member of	required high flow oxygen, with acute hypoxic respiratory lower lobe pneumonia ing collapse). led to establish and prevention and control revent and contain the to Resident #314, Resident Resident #329. taff members tested positive outpatient clinic/hospital. It was aware the staff tested to attempt by the facility to lents were exposed to the fort to isolate the residents for illity's policy. Residents for illity's policy. Residents 17/28/2021, four (4) days is series positive. During the lesting, Resident #314 and positive for COVID-19. Illid not quarantine the me spread of infection to 1, eight (8) days after the ve, when a plastic zip er the resident's doorway. Cumented staff were DVID-19 on 07/30/2021, stated she was not tested heduled shift on 07/31/2021. proximately 12:00 AM on dishe started feeling sick	{F O	00}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG		-		R
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		200 N	EET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE EVILLE, KY 41501	09/	/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	(X5) COMPLETION DATE
{F 000}	positive. Again, there evidence the facility a which residents SRN/shift. From 07/28/2021 thro additional three (3) re COVID-19, Resident Resident 328. Resi #329 were also hospit Prior to the barrier bei Resident #325, who re COVID-19 positive reswalking in the hallway hallway adjacent to CResident #325 was no 08/08/2021, Resident COVID-19. On 08/09, developed respiratory transferred to the emethospitalized. Resident the hospital to the fact 08/19/2021, Resident distress again, and was where he/she expired One (1) additional resitested positive for CO hospitalized on 08/14/08/15/2021 at the hospitalized Jeopardy (08/20/2021, and was expired)	ns to the nurse who ovID-19 test, which was was no documented tempted to determine A #13 cared for during her ugh 08/05/2021, an sidents tested positive for #329, Resident #82, and dent #82 and Resident falized due to COVID-19. Ing placed on 08/05/2021, esided across the hall from sidents, was observed as and sitting in a chair in the OVID-19 positive rooms. In the end of the end o	{F 0	00}			

CTATEMENT	DE DESIGNATION DE LA COMPANION					CINID IAC	<u>J. 0330-039 (</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		CONSTRUCTION		SURVEY PLETED
					<u>_</u>		R
*****		185256	B. WING			09	/30/2021
	ROVIDER OR SUPPLIER **POST-ACUTE AND RE	HABILITATION CENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE KEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL, SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	Resident #330, Resident #81 and Resident #81 and Resident #81 and failed were notified of weight Review of Resident #327, Resident #327, Resident #332, a records revealed each significant weight loss to have a systemic proresident weight loss. Tesident weight accondify the Registered lesident sustained we	nsure Resident #65, nt #327, Resident #82, ent #39, Resident #332, sident #40 maintained rs of nutritional status and/or d to ensure their physicians at loss. 65, Resident #90, Resident Resident #330, Resident and Resident #81's medical of the residents sustained due to the facility's failure ocedure in place to monitor The facility failed to obtain rding to policy, failed to Dietitian (RD) when a ight loss, failed to provide	{F 0	00)	DEFICIENCY)		
	dietary recommendati weight loss, failed to he preferences to prevent to ensure residents we portions to prevent we lin addition, Immediate 08/27/2021 and detern 05/02/2021 at 42 CFR Person-Centered Card 483.25 Quality of Card notified of the Immediate 08/27/2021. The facility failed to decare plan to address Fulcer risk, failed to ensure to prevent pressure care and treatments.	ons to prevent further nonor resident food at weight loss, and/or failed ere served adequate eight loss. De Jeopardy was identified on mined to exist on a 483.12 Comprehensive e Plans (F656) and 42 CFR et (F686). The facility was ate Jeopardy on evelop a comprehensive Resident #65's pressure sure Resident #65 received are ulcers, and failed to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WING			R	1
	ROVIDER OR SUPPLIER **POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, S 200 NURSING HOME LAN PIKEVILLE, KY 41501	NE	<u> 09/30</u>	0/2021
(X4) ID PREFIX TAG			ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE API DEFICIENCY)		ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA		(X5) COMPLETION DATE
{F 000}	03/23/2021 without pricated to turn and reported. On 05/02/20 developed a deep tiss. The facility failed to as (measurements, appeted.) as required. Subfailed to identify the printil 05/28/2021, when transferred to the Emedue to worsening of the #65 was admitted to the sacral wound and was decubitis (pressure) ultinfection including cell abscess". Resident #6 debridement on 05/30 tissue was removed at the bone". Resident #65 was real However, the facility or reposition Resident #6 weekly skin and/or pre Resident #65 developed ulcers, a Stage I (one) 06/23/2021, an unstage back of the left, lower (2) Stage II (2) pressure 08/26/2021. Further, a assessed Resident #6	mitted to the facility on essure ulcers. The facility sition the resident as 021, Resident #65 are injury to the coccyx. It is issues the pressure ulcer arance, drainage, odor, esequently, the facility also ressure ulcer had worsened in the resident was ergency Department (ED) are pressure ulcer. Resident the hospital for worsening is, "clinically septic with large cer with associated ulitis and possible 65 underwent surgical /2021, when all necrotic and "excision was down to dimitted to the facility. Ontinued to fail to turn and its saure ulcer assessments, and five (5) more pressure to the left heel on the right heel on the right heel on the left heel on the	{F 0	00)			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WNG				R
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
545444					200 NURSING HOME LANE		
PARKVIEV	N POST-ACUTE AND RE	HABILITATION CENTER			PIKEVILLE, KY 41501		
(X4) ID		ATEMENT OF DEFICIENCIES	ID.	_	PROVIDER'S PLAN OF CORRECTION		(76)
PREFIX TAG			PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	removal of the Immed 09/02/2021. A partial initiated on 08/25/202 09/10/2021, and deter Jeopardy was not rem 09/10/2021. Immedia identified on 09/10/20 Services (F725), 42 C (F835 and F837) and Assurance and Perfor (F867). The Immedia Based on the findings survey, concluded on determined the facility resources to effectivel order to maintain the Imental, and psychosoresident. Facility Adm Governing Body failed Assurance/Performan was implemented and to ensure systems we health and safety of refacility's AOC stated the "wound assessments" wound assessments wensure they had been	21 and the facility alleged liate Jeopardy effective extended survey was 1 and completed on rmined that the Immediate noved prior to exit on te Jeopardy was also 21 at 483.35 Nursing FR 483.70 Administration 42 CFR 483.75 Quality mance Improvement te Jeopardy is ongoing. of the partial extended 09/10/2021, it was failed to utilize their ly manage the facility in nighest practicable physical, icial well-being of each tinistration and the	{F 0	900)			
	revealed no document assessed their pressu required by the AOC. documented evidence weekly wound/pressur	ted evidence the facility re ulcers on 08/26/2021, as Further, there was no the facility was conducting re ulcer assessments for					
	AOC. Subsequently, t	e ulcers as stated in the there were no wound e for the facility to audit.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		0	(X3) DATE SURVEY COMPLETED				
		185256	B. WNG			R 09/3	0/2021
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	DDE	0310	072021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	200 300-00	ON SHOULD BE HE APPROPRIATE	E	(X5) COMPLETION DATE
(F 000)	residents would be was of 09/10/2021, ten weighed since 08/03/residents who had no 08/06/2021. Additional deficient pr F585, F609, F623, F6 at "D" level; F584, F8 level; F557, F802, F8 level; and F657 and I After supervisory revilmmediate Jeopardy 09/22/2021, and dete 03/26/2021 at 42 CF6 (F755). The facility was Jeopardy on 09/22/2021 at 42 CF6 (F755). The facility failed to p services to meet the Resident #326, Resident #321. The fadminister prescribed needs of Resident #324. In addition, the facility 07/16/2021 with the object of the pharmacy required over-ride and to receive an antibiotit The pharmacy required over-ride the medical dispensed. However, the cost over-ride and receive the physician	facility's AOC revealed eighed monthly. However, (10) residents had not been (2021, and seven (7) of been weighed since ractice was identified at (541, F689, F695, and F842, 104, F809 and F925 at an "E" (103, F806, and F812 at "F" (103, F806, and F812 at "F" (104, F809) and F812 at "F" (105) at "G" level. The ew, on 09/22/2021, was identified, on the ewild are exist on (104) at a continuous exist on (105) at a continuous exist exist on (105) at a continuous exist	{F 0	000}			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	I		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG_				R
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		200	REET ADDRESS, CITY, STATE, ZIP CODE 0 NURSING HOME LANE KEVILLE, KY 41501	09	/30/2021
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BI			COMPLETION DATE
{F 000} {F 557} SS=F	removal of the Immed 09/26/2021. The Stat determined the Immeremoved as alleged d 09/28-30/2021, which severity to "D" 42 CFF (F580), 483.12 Comp Care Plans (F655) (F0 Quality of Care (F684 Nursing Services (F72 Pharmacy Services (F73 Pharmacy Services (F74 A3.12 Freedom from 483.25 Quality of Care Administration (F835) Quality Assurance and Improvement (F867), Infection Control (F88 monitors the effective and quality assurance Respect, Dignity/Righ CFR(s): 483.10(e)(2) §483.10(e) (Respect a The resident has a rig and dignity, including: \$483.10(e)(2) The right possessions, including as space permits, unleupon the rights or hearesidents. This REQUIREMENT by: Based on observation	5/2021, which alleged liate Jeopardy on se Survey Agency diate Jeopardy was uring a revisit conducted on lowered the scope and R 483.10 Resident Rights rehensive Person-Centered 656), 42 CFR 483.25 (F686), 42 CFR 483.45 (F755); and to "E" at 42 CFR Abuse (F600), 42 CFR e (F692), 42 CFR 483.70 (F837), 42 CFR 483.75 d Performance and 42 CFR 483.80 (Performance) activities. It to have Prsnl Property to have Prsnl Property and Dignity. The to retain and use personal grunnishings, and clothing, less to do so would infringe lith and safety of other is not met as evidenced in, interview, and facility	{F 0		Preparation and execution of this plan	of	11/16/21
	policy review, it was d	etermined the facility failed			correction does not constitute admission		

DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	185256	B. WING_				R
OVIDER OR SUPPLIER POST-ACUTE AND RE	HABILITATION CENTER		20	00 NURSING HOME LANE	09/	/30/2021
SUMMARY STATEMENT OF DEFICIENCIES ((EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	COMPLETION DATE
to protect residents' d (108) out of one hund the facility. Observatio 06/15/2021, revealed observed to have plas cups, and styrofoam to observation of the bre revealed residents we	ignity for one hundred eight red nine (109) residents in on of the noon meal on residents' meal trays were stic silverware, styrofoam powls. In addition, akfast trays on 06/16/2021, are being served food in	{F 5	57}	of the facts alleged or conclusions set forth in the statement of deficiency. Th plan of correction is prepared and	is	
The findings include:				F 557 Respect, Dignity/Right to have personal property.		
Rights", dated June 20 would be treated with full recognition of their care for their needs. T	020, revealed each resident consideration, respect, and dignity and individuality in the policy also stated the			and #92 are provided regular silverware glasses and dishes unless they have	€,	
06/15/2021 at 1:14 PM were being served wit	/l, revealed residents' meals h plastic silverware,			Criteria 2: All residents had the potent to be affected by this cited deficiency. Nother residents were noted to be using Styrofoam or plastic dishware.	tial Vo	
at 8:30 AM, revealed a styrofoam cups and st Group interview condu- Residents #3, #16, #3 26/16/2021 at 10:13 A supper trays had plast hard to cut anything, e esidents also stated to styrofoam cups and be Continued interview re	residents' meal trays had syrofoam bowls on them. sucted with six (6) residents (38, #51, #92, and #96), on (40, and their lunch and the specially meats. The they had been receiving owls which they did not like, evealed they had received			needed items were submitted and received and put into service on 11/3/2' b) Dietary staff have received in-service education by the Dietary Manager/Dietary Consultant as completed by 11/1//21 on protecting	1.	
	CORRECTION DIVIDER OR SUPPLIER POST-ACUTE AND RESUMMARY STA (EACH DEFICIENCY REGULATORY OR LEST CONTINUED From pages to protect residents' de (108) out of one hund the facility. Observation of the brest cups, and styrofoam bowls and styrofoam cups. The findings include: Review of the facility's Rights'', dated June 26 would be treated with full recognition of their care for their needs. The sident had a right to continue the breat 8:30 AM, revealed restrofoam cups, and styrofoam cups and stated to cut anything, elesidents also stated to continued interview restrofoam cups and becontinued intervi	DOUDER OR SUPPLIER POST-ACUTE AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 to protect residents' dignity for one hundred eight (108) out of one hundred nine (109) residents in the facility. Observation of the noon meal on 06/15/2021, revealed residents' meal trays were observed to have plastic silverware, styrofoam cups, and styrofoam bowls. In addition, observation of the breakfast trays on 06/16/2021, revealed residents were being served food in styrofoam bowls and styrofoam cups on their meal trays. The findings include: Review of the facility's policy titled," Resident Rights", dated June 2020, revealed each resident would be treated with consideration, respect, and will recognition of their dignity and individuality in care for their needs. The policy also stated the resident had a right to a dignified existence. Observation of the lunch meal service on 06/15/2021 at 1:14 PM, revealed residents' meals were being served with plastic silverware, styrofoam cups, and styrofoam bowls. Observation of the breakfast meal on 06/16/2021 at 8:30 AM, revealed residents' meal trays had styrofoam cups and styrofoam bowls on them. Group interview conducted with six (6) residents Residents #3, #16, #38, #51, #92, and #96), on 06/16/2021 at 10:13 AM, revealed their lunch and supper trays had plastic silverware which made it lard to cut anything, especially meats. The esidents also stated they had been receiving styrofoam cups and bowls which they did not like. Continued interview revealed they had received the plastic silverware, styrofoam cups and bowls which they did not like. Continued interview revealed they had received the plastic silverware, styrofoam cups and bowls	DONDER OR SUPPLIER POST-ACUTE AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 to protect residents' dignity for one hundred eight (108) out of one hundred nine (109) residents in the facility. Observation of the noon meal on 05/15/2021, revealed residents' meal trays were observed to have plastic silverware, styrofoam cups, and styrofoam bowls. In addition, observation of the breakfast trays on 06/16/2021, revealed residents were being served food in styrofoam bowls and styrofoam cups on their meal trays. The findings include: Review of the facility's policy titled," Resident Rights", dated June 2020, revealed each resident would be treated with consideration, respect, and full recognition of their dignity and individuality in care for their needs. The policy also stated the resident had a right to a dignified existence. Observation of the lunch meal service on 05/15/2021 at 1:14 PM, revealed residents' meals were being served with plastic silverware, styrofoam cups and styrofoam bowls on them. Coopy interview conducted with six (6) residents at 8:30 AM, revealed residents' meal trays had styrofoam cups and styrofoam bowls on them. Group interview conducted with six (6) residents Residents #3, #16, #38, #51, #92, and #96), on 05/16/2021 at 10:13 AM, revealed their lunch and supper trays had plastic silverware which made it hard to cut anything, especially meats. The esidents also stated they had been receiving styrofoam cups and bowls which they did not like. Continued interview revealed they had been received the plastic silverware, styrofoam cups and bowls which they did not like. Continued interview revealed they had received the plastic silverware, styrofoam cups and bowls	DOUDER OR SUPPLIER POST-ACUTE AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 to protect residents' dignity for one hundred eight (108) out of one hundred nine (109) residents in the facility. Observation of the noon meal on 06/15/2021, revealed residents' meal trays were observed to have plastic silverware, styrofoam cups and styrofoam bowls. In addition, observation of the breakfast trays on 06/16/2021, revealed residents were being served food in styrofoam bowls and styrofoam cups on their meal trays. The findings include: Review of the facility's policy titled," Resident Rights", dated June 2020, revealed each resident would be treated with consideration, respect, and full recognition of their dignity and individuality in care for their needs. The policy also stated the resident had a right to a dignified existence. Observation of the lunch meal service on 06/16/2021 at 1:14 PM, revealed residents' meals were being served with plastic silverware, styrofoam cups, and styrofoam bowls. Observation of the breakfast meal on 06/16/2021 at 8:30 AM, revealed residents' meal trays had styrofoam cups and styrofoam bowls on them. Group interview conducted with six (6) residents Residents #3, #16, #38, #51, #92, and #96), on 06/16/2021 at 10:13 AM, revealed their lunch and supper trays had plastic silverware which made it land to cut anything, especially meats. The esidents also stated they had been receiving tyrofoam cups and bowls which they did not like. Continued interview revealed they had received he plastic silverware, styrofoam sups and bowls	The findings include: Review of the facility's policy titled," Resident would be treated with consideration, respect, and ultrecognition of the breakfast meal trays were being served with plastic silverware, styrofoam cups and byrofoam bowls. Review of the facility's policy titled," Resident and aright to a dignified existence. Dispervation of the breakfast meal on 06/16/2021 at 1:14 PM, revealed residents' meal trays were seing served with plastic silverware, styrofoam bowls. Review of the facility's policy titled," Resident and the seident had a right to a dignified existence. Dispervation of the breakfast meal on 06/16/2021 at 1:14 PM, revealed residents' meal trays on 06/16/2021 at 1:14 PM, revealed residents' meal trays on 06/16/2021 at 1:14 PM, revealed residents' meal trays on 06/16/2021 at 1:14 PM, revealed residents' meal trays on 06/16/2021 at 1:14 PM, revealed residents' meal trays on 06/16/2021 at 1:14 PM, revealed residents' meal trays on 06/16/2021 at 1:14 PM, revealed residents' meal trays on 06/16/2021 at 1:14 PM, revealed residents' meal trays on 06/16/2021 at 1:14 PM, revealed residents' meal trays on 06/16/2021 at 1:14 PM, revealed residents' meal trays on 06/16/2021 at 1:14 PM, revealed residents' meal trays on 06/16/2021 at 1:14 PM, revealed residents' meal trays on 06/16/2021 at 1:14 PM, revealed residents' meal trays on 06/16/2021 at 1:14 PM, revealed residents' meal trays on 06/16/2021 at 1:14 PM, revealed residents' meal trays on 06/16/2021 at 1:14 PM, revealed residents' meal trays on 06/16/2021 at 1:14 PM, revealed residents' meal trays on 06/16/2021 at 1:14 PM, revealed residents' meal trays on 06/16/2021 at 1:14 PM, revealed residents' meal trays on 06/16/2021 at 1:14 PM, revealed their hunch and upper trays had plastic silverware which made it tard to cut anything, especially meats. The secidents and the potential trays and 06/16/2021 at 1:14 PM, revealed their hunch and upper trays had plastic silverware which made it tard to cut anything, especially meats. The secidents and	DISPERIENCE TO THE PROPERTY STATE ADDRESS, CITY, ST

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R 30/2021	
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER	-' -	20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	<u> </u>	30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
{F 557}	at 2:00 PM, revealed silverware, styrofoam for a few weeks. The out of bowls, cups, ar styrofoam bowls and Interview with DA #2 revealed they had be styrofoam cups, and shad worked there, two stated they had been silverware. Interview with the Die 06/16/2021 at 1:30 Pl 06/15/2021. The DM silverware, cups, and was aware this was a disposable dishes an interview with the DM the needed supplies to never got the supplies budget issue. Interview conducted were got the supplies to the supplies of the supplies	Aide (DA) #1 on 06/16/2021 they had been using plastic cups, and styrofoam bowls DA stated they had been and silverware and had used cups and plastic silverware. On 06/16/2021 at 2:15 PM, en using plastic silverware, styrofoam bowls since he of (2) weeks ago. The DA out of bowls, cups, and out of bowls, cups, and out of bowls, cups, and stated the facility was out of bowls. The DM stated she of dignity issue with using dignity issue with usi	{F 5	557}	residents unless they have specific ord which contraindicate this, or repairs are underway for the dishwasher, and the need to notify the Dietary Manager whe the last available box of dishware is pur into service, so that an order may be placed to maintain supply. Criteria 4: a) The Dietary Manager whonitor available dishware supplies monthly to determine when additional supplies need to be Ordered. Audits will be monthly for 3 months. b) Residents will be asked each resident council meeting if they are being served their meals utilizing regular dishware. The Activity Director/Designee will notifithe Dietary Manager for follow up of any residents who report they are not being served meals on regular dishware. Audits will be reviewed at QAPI monthly x3 months and then quarterly until in substantial compliance. Criteria 5: Date of compliance: 11/16/2021	en t ill ed Lin ee		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI	FIPLE CONSTRUCTION NG			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			1	R 30/2021	
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STAT 200 NURSING HOME LANE PIKEVILLE, KY 41501	TE, ZIP CODE	1 03/	30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD B SED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE	
{F 557}	facility for two (2) wee talked with the DM an told her about using s and plastic silverware there was no problem cups and bowls.	e had only been at the ks. She stated she had dthe RD and they had not tyrofoam cups and bowls. The Administrator stated with ordering replacement ury/Decline/Room, etc.)	{F 5					
SS=D	S483.10(g)(14) Notification (i) A facility must immoconsult with the residence consistent with his or representative(s) when (A) An accident involves results in injury and happysician intervention (B) A significant changemental, or psychosocideterioration in health status in either life-throclinical complications) (C) A need to alter treatment due to advect commence a new form (D) A decision to transfers and the facility when making notife (14)(i) of this section, all pertinent information is available and provide physician. (iii) The facility must all	ation of Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident in there is- ing the resident which as the potential for requiring ge in the resident's physical, all status (that is, a , mental, or psychosocial eatening conditions or ; atment significantly (that is, an existing form of rse consequences, or to n of treatment); or ifer or discharge the ty as specified in ication under paragraph (g) the facility must ensure that in specified in §483.15(c)(2) led upon request to the	{F 5	80}			12/30/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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1	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09	/30/2021	
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{F 580}	as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section. (iv) The facility must rupdate the address (riphone number of the representative(s). §483.10(g)(15) Admission to a composite dis §483.5) must disclose its physical configurat locations that comprisional part, and must specify room changes between under §483.15(c)(9).	or roommate assignment (0(e)(6); or ent rights under Federal or ins as specified in paragraph (ecord and periodically inailing and email) and resident (estinct part. A facility estinct part (as defined in er in its admission agreement ion, including the various set the composite distinct or the policies that apply to en its different locations	{F 5	80}			
	This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of facility policy, it was determined the facility failed to notify the physician for nine (9) of fifty-seven (57) sampled residents when the resident			F 580 Notify of Changes (Injury/Decline/Room, etc.) Criteria 1: a) Resident #321 was			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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10.1112 01 11	NOTICE!! ON SOFTEEN				TREET ADDRESS, CITY, STATE, ZIP CODE		
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{F 580}	Continued From page	14	{F 5	80}			
	experienced a signific	ant change in status and a	`	•	discharged from this facility on 7-19-20	21	
	need to alter treatmer	nt (Resident #321, Resident			b) Resident #323 was	٤١.	
	#323, Resident #90, I	Resident #327, Resident			discharged from this facility on 7-20-20	21	
		Resident #39, Resident			c) Resident #82 was	41.	
	#332, and Resident #		İ		discharged from facility on 8-9-2021		
	,	,-			d) Resident #327 was		
	On the morning of 07	/18/2021, before breakfast,			discharged from facility on 8-15-2021		
		nt #321's blood glucose			e) Resident #332 was		0
	level, which was 67 m				discharged from facility on 9-1-2021	ļ	100
		ge 70 mg/dL to 110 mg/dL).	İ		d) Residents #90, #330,		
	However, there was r	o evidence the staff notified			#39,and #81 were weighed on 9-17-20	21.	
	the resident's physicia	an of the resident's low			The registered dietician completed a	- ` '	
	glucose levels. Later	that afternoon, sometime			comprehensive nutrition assessment fo	ır İ	
	after 3:00 PM, staff fo				the residents by 9-17-2021. The Direct		
	unresponsive with a b	lood glucose level of 40			of Nursing or designee reviewed the		
	mg/dL. Interviews with				comprehensive assessment		
		it #321 both injectable and			recommendations, spoke with the		
	oral glucose, and the	resident regained			attending MD and validated the diet		
	consciousness. Howe				orders, and recommendations were		
		in the resident's medical			entered into PCC and matched the Din		
		resident's second episode of			RD tray card. The registered dietician a	ind	ľ
		staff notified the resident's			Director of Nursing reviewed diet orders	s in	
		2021, at approximately 12:30			PCC to ensure they matched the orders	s in	
		ent #321 unresponsive and			Dining RD.	-	
		nd record review revealed					
		lucose was 32 mg/dL. Staff			Criteria 2: a) All residents were		
	again administered th				assessed with diagnosis including:COP		
	glucagon and oral glu				Asthma, or current pneumonia were by		- 1
	transferred Resident	#321 to the hospital, where			licensed nurses and/or respiratory		
		nosed with acute metabolic			therapist to ensure they were in no		
	encephalopathy and I				respiratory distress. No concerns were	.	
		mia. The hospital admitted			identified as completed 8-12-2021. On	.	
	resident #321 to the	Intensive Care Unit (ICU).			8/14/2021 all residents with diagnosis of	of	
	Further the feether	mitted Besident #200			diabetes was assessed for s/s of	.	
	Further, the facility admitted Resident #323 on		hyper/hypoglycemia. None were pres			ŀ	
		07/06/2021 after being on a ventilator at the expression ospital. At approximately 7:30 AM on 7/20/2021.		b) All residents with orders			
		lately 7:30 AM on 7/20/2021, the resident's room and	for glucose monitoring were reviewed			· .	
					the Regional Nurse and orders amende	ed	
	discovered the teside	nt was sweaty, clammy, and	1		to include mandatory entry of glucose		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		185256	B. WNG				/30/2021
NAME OF PI	ROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DADKME	** DOCT 400 TE 4ND DE			2	00 NURSING HOME LANE		
PARKVIEV	W POST-ACUTE AND RE	HABILITATION CENTER		PIKEVILLE, KY 41501			
(X4) ID		ATEMENT OF DEFICIENCIES	ID				(X5)
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(F 580)	Continued From page		{F 5	80}			
	having difficulty breat	hing. However, there was	-		value on the MAR vs. a check for		
	no evidence that staff	notified the resident's			completion.		
	physician of the resid				c) The DON and Registere	d	
	resident's family came	e to visit and insisted the			Dietician reviewed weights for all		li
	facility transfer the re-				residents to identify any that had		
	Resident #323 was a	dmitted to the hospital and			demonstrated significant weight change	es.	
	diagnosed with acute				For any residents demonstrating		
	insufficiency, and left	lower lobe pneumonia			significant weight changes, the register	ed	
	versus Atelectasis (Iu	ng collapse).			dietician completed a comprehensive		
	In addition the facility	Selfed to account the self-self-self-self-self-self-self-self-		ļ	nutrition assessment by 9-20-2021. The		
		r failed to ensure Resident			DON or designee and RD validated the		
	#330, Resident #39, F	Resident #82, Resident			diet orders, and recommendations wer]
		cians were notified when the			entered into PCC and matched the Din]
	residents sustained s		-		RD tray card. The registered dietician a Director of Nursing reviewed diet order] [
		igimioant weight 1000.			PCC to ensure they matched the order		
	The facility's failure to	ensure residents received	-		Dining RD.On 9-19-2021 Regional Nur		
	treatment and care in	accordance with			reviewed SBARs to identify residents w		
		s of practice, has caused or			had a change in condition not related to		
		ous injury, harm, impairment			weights, glucose levels or respiratory	•	
	or death to a resident	. Immediate Jeopardy was			concerns.		
		021, and was determined to					
		at 42 CFR 483.10 Resident			Criteria 3: a) The Respiratory Therap	ist	
		R 483.12 Freedom from			and/or designee educated Licensed		
		R 483.12 Comprehensive			nurses on notification of MD with		
		e Plans (F655), (F656), 42			respiratory decline or distress beginnin	g	
		of Care (F684) (F686),			8-12-2021.		[]
		15 Pharmacy Services			b) The DON/Designee		
		83.80 Infection Control			educated all licensed nurses on identify	/ing	i
		as notified of Immediate			signs/symptoms of		!
	Jeopardy on 08/11/20	141.			hyperglycemia/hypoglycemia, facility		[
	An accentable Allegai	tion of Compliance (AOC)			diabetic protocol, documenting residen	i	
	was received on 09/0				change in condition, documentation of		
	removal of the Immed				blood sugar in the medical record,		
		r, the AOC could not be			notification of physician and following		1
		ervations, staff interviews,			physician orders beginning on		
		documentation. Additional			08-12-2021.Beginning on 8-12-2021 De or Designee educated licensed staff on		
		was identified at 42 CFR			acute condition changes clinical protoc		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY
	185256	B. WING				R
NAME OF PROVIDER OR SUPPLIER			Si	TREET ADDRESS, CITY, STATE, ZIP CODE	09/	/30/2021
PARKVIEW POST-ACUTE AND	REHABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501			
PREFIX (EACH DEFICI				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
Administration (F8 Quality Assurance Improvement (F86 the Immediate Jeopar A second acceptal was received on 0 removal of the Immediate Jeopar A second acceptal was received on 0 removal of the Immo9/26/2021. The determined the Immediate Jeopar A second acceptal was received on 0 removal of the Immo9/26/2021. The determined the Immediate Jeopard Assurance Improvement (F86), 483.12 Co Care Plans (F655) Quality of Care (F6 Nursing Services (Pharmacy Service 483.12 Freedom fit 483.25 Quality of Administration (F8 Quality Assurance Improvement (F86 Infection Control (Improvement	ervices (F725), 42 CFR 483.70 35) (F837), 42 CFR 483.75 and Performance i7). The facility was notified of opardy on 09/10/2021. The dy is ongoing. It is ongo	{F 5	680}	c) Residents who are weight weekly are weighed every Monday by CNAs. -CNAs report weights to the nurse wereviews and enters the weight into PCC -Any 5lb weight change or more will verified by obtaining a re-weight by the next day. -Once the weight is verified, any significant change and/or 5lb weight lost or gain will be reported by the nurse to MD and RD for recommendations/ordernNew orders will be reflected on the care plan, with the resident and or RP notified. d) Monthly weights are obtained in the same manner the first week of earnonth. e) All weights are reviewed in the weekly weight meeting by the IDT which consists of: Registered Dietician, Director Nursing, MDS, Social Services, Activities, Dietary, Therapy and Clinical Staff Representative. The DON is responsible for running this meeting/process. Daily weights are reviewed by licensed staff and reported the MD if significant weight changes no by the nurse. f) All nursing staff were educa by 9-20-21 by the Director of Nursing, MDS coordinator or designee on proper weighing techniques, obtaining, documenting, and reporting of weight changes to the Registered Dietician. Beginning 11/24/2021 All agency staff and new hires will be educated on the processor of the floor.	be ss the rs. ed ach the h to ted	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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PARKVIEV		HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	1 03/	
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{F 580}	baseline information in eurological status, consciousness, cognionset, duration and stabs, history of psychiallness or depression, current medications. contact the physician situation, and for emergage the physician arresponse. Review of the facility's of Hypoglycemia", darevealed staff may nenotification to the phyhad not eaten well or for two (2) or more dared Hypotension, lethargy, who was lethargic, burnight include oral glubuccal mucosa, intranadministration of intraimmediate notification. Review of Resident revealed the facility at 07/16/2021 with diagrurosepsis, Diabetes it Bladder Cancer. Review of Resident # (MDS) assessment dathe facility assessed to Interview for Mental Status in the facility assessed to the facility asses	ss, document, and report including; vital signs, urrent pain level, level of tive and emotional status, everity of illness, recent static disturbances, mental all active diagnoses, and all The nurse would then based on urgency of the ergencies, they would call or and request a prompt s policy titled, "Management ted November 2020, ed to make urgent sician if a diabetic resident consumed sufficient fluids eys and had a fever, or confusion. For a resident at not comatose, treatment cose paste rubbed into muscular glucagon, or the evenous dextrose and at to the physician. t #321's medical record dmitted the resident on moses that included Mellitus, and Invasive 321's Minimum Data Set ated 07/19/2021 revealed he resident to have a Brief status (BIMS) score of iility assessed the resident	{F \$	580}	g) On 8-31-21 the Dietary Manager was educated by the Regional CDM on diet order accuracy and provision of timely nutritional assessment to ensure diet order accuracy, when the diet order are put into PCC the nurse entering the order will send written communication to the dietary staff that will include diet and texture. Dietary Manager will enter the order into the tray care system. All diet orders from the previous day should be reviewed in clinical meeting to ensure accuracy and communication was completed. h) By 9-20-21 the Director of Nursing educated nurses and Dining Director of the process for entering, activating, and implementing the registered dietician recommendations for dietary orders. i) Snacks are being offered daily morning and afternoon by the restorative or activity aides or designed all residents. Criteria 4: a) During the Ad-hoc QAP meeting on 08-12-2021 the above lister education and processes were reviewed and audits put into place to ensure compliance with this process. DON/Designee completed audits of state knowledge with verbal quizzing of identification and assessment of reside with a change in respiratory status, identifying signs/symptoms of hyperglycemia/hypoglycemia, SBARS and notification. Staff were quizzed randomly across all shifts; beginning we of 8/15/2021 5 staff were quizzed week	of differents to the differents to the differents to the different to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	V POST-ACUTE AND RE	HABILITATION CENTER		2	00 NURSING HOME LANE		
				P	PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE
{F 580}			{F 5	80}			
	Review of Resident #321's Baseline Care Plan dated 07/16/2021, revealed the care plan did not include the resident's diagnosis of Diabetes Mellitus. Review of Resident #321's Physician Orders Summary Report, revealed Physician's Orders dated 07/17/2021, which stated staff were to monitor for signs/symptoms of hypoglycemia/hyperglycemia (low/high blood sugar) every shift, obtain blood glucose levels as needed and to notify the physician if blood glucose was below 70 mg/dL or above 350 mg/dL. Review of Resident #321's Medication Administration Record (MAR) for June 2021, revealed the MAR had an entry stating diabetic monitoring every shift for hypoglycemia/hyperglycemia, may complete finger sticks as needed, and to notify the physician if blood glucose was below 70 mg/dL or above 350 mg/dL. Review of Nursing Notes dated 07/18/2021 at 3:20 PM, revealed at approximately 7:30 AM on 07/18/2021, Licensed Practical Nurse (LPN) #6 obtained a blood glucose reading for Resident #321, which was 67 mg/dL. The Note stated that after breakfast, LPN #6 obtained a follow-up blood glucose level, which she documented as 139 mg/dL. However, there was no indication or documentation that LPN #6 notified the resident's physician when the resident's blood glucose				x4 then monthly x 2. Audits will be reviewed at QAPI monthly x3 months a then quarterly until in substantial compliance. b) Beginning 11/24/21 DON/Designee		
					monitor documented blood sugar results daily Monday thru Friday (Weekend will be reviewed Monday) or until compliance is met in morning clinical meeting and any blood sugar results outside of normal range will be reviewed for MD notification and implementation of any physician orders. Care Plan will be reviewed and updated as needed. Audits will be reviewed at QAPI monthly x3 months and		
					then quarterly until in substantial compliance c) Beginning 11/24/21 TI DON/Designee will monitor respiratory assessments and SBAR communication for acute change in condition or change respiratory status, any acute change condition or change in respiratory statu will be reviewed for MD notification and implementation of any physician order. Care Plan will be reviewed and update as needed. Audits will be weekly x 4 th monthly x 2. Audits will be reviewed at QAPI month x3 months and then quarterly until in substantial compliance d) Beginning 11/24/2021 New interventions will be care planned	ns e in s d den	
	dropped below 70 mg no evidence the LPN resident for signs/sym	n/dL. In addition, there was continued to monitor the optoms of lycemia or re-checked the			the morning meeting by the DON, ADON or nursing designee. Audits will be reviewed at QAPI monthly x3 months and then quarterly until in substantial compliance. e) Starting 11/24/2021		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WING				R 30/2021
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 037	30/2021
				2	200 NURSING HOME LANE		
PARKVIEV	V POST-ACUTE AND RE	HABILITATION CENTER			PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 580}	08/02/2021 at 5:30 President on 07/18/202 at 10:45 AM for a sch Resident #321 told he dropped to 67 mg/dL daughter stated no st blood glucose level or signs/symptoms of hy while she was at the approximately 3:00 Provided the resident with Resident #321 or on 07/18/2021 at 2:19 Provided the resident told the spounot re-checked his/her blood glucose in the resident with LPN #6 revealed on the morn obtained a blood glucose aft was back up to 139 m could not recall if she the resident's blood ground she did not need the resident's blood ground she did not need the resident's blood ground the resident's blood ground she did not need the resident's blood ground/she and she did not need the resident's bloo	ant #321's Daughter on M, revealed she visited the 21 and arrived to the facility reduled visit. She stated er his/her blood sugar had that morning. However, the aff re-checked the resident's rassessed the resident for proglycemia/hyperglycemia facility from 10:45 AM until M. Int #321's Spouse on M, revealed he/she talked in the phone numerous times he resident reported feeling cose was low. However, the use at 4:00 PM, that staff had er blood sugar since early sher blood glucose was low. So on 07/27/2021 at 4:10 PM, sing of 07/18/2021, she cose of 67 mg/dL for stated she re-checked the er the breakfast meal and it mg/dL. LPN #6 stated she notified the physician that plucose had dropped below the LPN stated that since the ose came up to 139 mg/dL, the resident was doing well, to notify the physician that plucose had dropped below	{F 5	80)	snack intake will be audited by Dietary Manager daily for 1 week; weekly for 3 weeks; monthly thereafter for 2 months then quarterly until in substantial compliance. Audits will be reviewed at QAPI monthly x3 months and then quarterly until in substantial compliance f) All weights are reviewed in the weekly Wednesday at-risk meeti to ensure all notifications and care plar are updated by the IDT which consists Registered Dietician, Director of Nursin MDS, Social Services, Activities, Dietar Therapy and Clinical Staff Represental The DON is responsible for running this meeting/process. g) Beginning 11/24/2021 the DON or designee will audit weekly weights weekly x 4 weeks then monthly 2 months to ensure no significant weight changes. If weight changes are present then MD, RP and RD will be notified. Criteria 5: Date of Compliance 12/30/2021	ed ng ns of: ng, ry, sive. s	
		#1 on 07/27/2021 at 4:40 s working on 07/18/2021					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION ING		(X3) DATE COMP	SURVEY LETED
		185256	B. WNG			R 09/30/2021	
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 200 NURSING HOME LANE PIKEVILLE, KY 41501	E	031	5072021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE		(X5) COMPLETION DATE
{F 580}	stated she did recall fill blood sugar of 67 mg. interview with SRNA in PM, revealed later that Resident #321's room time unknown, and for non-responsive and in She stated LPN #6 go of the unit to help her working with the resident episode during the lat but could not recall the stated it was after lune netered the room the and she obtained a bing/dL. She stated she end of the unit to assi injection of Glucagon oral glucose and the in LPN #6 stated following the resident's blood go "around 139 mg/dL", stated she notified the hypoglycemic event. #321's medical record documentation of the of the resident's blood documentation that Life the event. Interview with Registe 07/30/2021 at 10:54 / working on 07/18/202 to 7:00 PM, and recal	Resident #321 having a AdL that morning. Additional Add	{F 5	580}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	1	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				२ 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE		(X5) COMPLETION DATE
{F 580}	40 mg/dL. RN #1 state room the resident was stated they administe injection, and the resi consciousness. Howe the resident's blood si #6 administered the resident #321's bloom mg/dL. RN #1 stated of the unit, and did not the physician regardinand the resident's low. Review of Resident # revealed an entry date stating staff had found with a blood glucose of stated staff administered labored labo	and a blood glucose level of eed when she arrived to the shon-responsive. RN #1 red the resident a Glucagon dent began to regain ever, according to RN #1, ugar remained low, and LPN esident oral glucose. RN #1 ring the oral glucose, at glucose came up to 111 she then returned to her end at know if LPN #6 contacted and the hypoglycemic event ar blood glucose level. 321's Nursing Notes ed 07/19/2021 at 12:23 AM, at the resident unresponsive for 32 mg/dL. The note first two first and oral glucose. However, and oral glucose. However, and oral glucose and oreathing. Staff notified the first and received orders to send spital. Continued review of ealed Emergency Medical er facility at 1:00 AM and and to the hospital ent (ED). Cords for Resident #321 I interview with the ED first at 8:22 PM, revealed	{F 5	580}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE COMP	SURVEY
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NAME OF PI	ROVIDER OR SUPPLIER	100200	2	SI	TREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
PARKVIEV	V POST-ACUTE AND RE	HABILITATION CENTER		20	00 NURSING HOME LANE IKEVILLE, KY 41501		:
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 580}	Interview with Physici physician, on 08/04/2 did not recall staff not #321's hypoxic event breakfast or the hypowhen staff found the Physician #1 stated if morning of 07/18/202 a blood glucose of 67 the resident to the hophysician #1 also staremembered staff not #321 was during the 07/19/2021, when stanonresponsive. Interview with the Dire 08/11/2021 at 12:05 Fexpected nursing staff resident had a change a nursing assessmen stated she was not avent two hypoglycemic epinotification occurring the hospital on 07/19/with the DON reveale routine monitoring or ensure physician notificand as warranted. Interview with the Adritso PM, revealed she conduct a nursing assessmen conduct and as warranted.	an #1, Resident #321's 021 at 1:05 PM revealed he ifying him of Resident on 07/18/2021 before exic event that afternoon, resident unresponsive. Istaff had notified him on the 1, when Resident #321 had img/dL, he would have sent spital for evaluation. ted the only time he ifying him about Resident early morning hours of iff found Resident #321 ector of Nursing (DON) on PM revealed that she if to notify the physician if a is in condition and complete t on the resident. The DON ever that Resident #321 had sodes without physician prior to the resident going to 2021. Continued interview d she did not conduct have any system in place to fication was occurring timely ministrator on 08/10/2021 at the expected nursing staff to sessment anytime a resident ition and notify the physician dministrator stated she was	{F 5				
		emia However, she stated					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRU	ICTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	EHABILITATION CENTER		200 NURSIN	DRESS, CITY, STATE, ZIP CODE NG HOME LANE E, KY 41501	USI	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	-	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI ROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 580)	revealed the facility a 07/06/2021, with diag Metabolic Encephalog Failure, Autistic Disor Mellitus, Dysphagia, I Review of Resident # (MDS) Admission ass revealed the facility a severely impaired cog Interviews on 07/28/2 Registered Nurse Aid PM with SRNA #15, r 07/20/2021 at approx observed Resident #3 red faced, and having they stated was not n SRNA #14 stated she resident's change in administered the resident's change in administered the resident to the resident contilibreathing. SRNA #14 "breathing pretty hard administered the residenting treatment "a couple h SRNAs stated Resided difficulty breathing. Of the resident's family a approximately 11:15 / send the resident to the Interview with RN #6 revealed on 07/20/20 AM, staff notified her "congested". She state assigned nurse to Re	ant #323's medical record idmitted the resident on gnoses that included pathy, Acute Respiratory rider, Sepsis, Diabetes Pneumonia and Aphasia. #323's Minimum Data Set sessment dated 07/13/2021, issessed the resident to have gnition. #2021, at 11:43 AM, with State le (SRNA) #14, and at 2:35 revealed on the morning of simately 7:15 AM, they make the resident in the resident. It is notified RN #6 of the condition, and the nurse dent a breathing treatment, in the resident was difficulty in the resident was difficulty in the resident was difficulty in the resident was difficulty in the resident was difficulty in the resident was difficulty in the resident was difficulty in the resident was difficulty in the resident was difficulty in the resident was difficulty in the resident was difficulty in the resident was difficulty at the facility at the facility at the facility at the facility at approximately 7:15 that Resident #323 was	{F 5	80}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRU IG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER POST-ACUTE AND RE	HABILITATION CENTER		200 NURSIN	DRESS, CITY, STATE, ZIP CODE NG HOME LANE F, KY 41501	1	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI ROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 580}	resident had audible vaccessory muscles to stated she had last se approximately 6:15 Al having difficulty breath respiratory distress withowever, RN #6 state resident's physician to change in condition, bresident's assigned nuterious was 3:45 PM, and review of Administration Record administered a breath #323 at 7:43 AM, which some improvement in according to RN #6, the long and the resident's stated she administer breathing treatment at that LPN #3 would no resident's condition. Interview with LPN #3 nurse assigned to Resident's condition. Interview with LPN #3 nurse assigned to Resident's condition. Interview with LPN #3 nurse assigned to Resident's condition. Interview with LPN #3 nurse assigned to Resident's condition. Interview with LPN #3 nurse assigned to Resident's condition. Interview with LPN #3 nurse assigned to Resident's condition. Interview with LPN #3 nurse assigned to Resident's according to Resident However, at approxime "something was going stated she assessed to fast and using access breathing. LPN #3 stated that around 8:15 AM ara chest x-ray. However	red the resident's room, the wheezing and was using aide in breathing. RN #6 en Resident #323 at M, and the resident was not ning at that time, and the as new for the resident. ed that she did not notify the preport the resident's recause LPN #3 was the arse. RN #6 stated it was at to call the physician. With RN #6 on 07/28/2021 at of Resident #6's Treatment of (TAR) revealed she ing treatment to Resident with breathing. However, the improvement did not last as status declined. RN #6 ed the resident another at 11:34 AM, and assumed tify the physician of the revealed she was the sident #323 on 07/20/2021. Froximately 6:30 AM on #323 "seemed ok". The improvement to be breathing ory muscles to aide in the different was notified Physician and received a new order for ear, there was notified the resident's medical	{F 5	30}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501	1 09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 580}	treatments administer #323 condition "staye Continued interview with resident's family of and immediately requested an order to thospital. Interview with Reside 08/02/2021 at 8:50 All the facility on 07/20/2 AM. She revealed that he/she could hear the hallway. The family more requested the resident evaluation. Further review of the 07/20/2021, revealed the facility staff notified until after the resident the facility. Review of change of condition for which stated the resident the facility. Review of change of condition for which stated the resident that 11:45 AM, and commentation that the facility with Physician #1 at 11:45 AM, and of Resident #323 to the Interview with Physician Physician #1 stated if chest x-ray would not for a resident exhibiting the provided the resident exhibition of a resident exhibition of the physician #1 stated if the	that following the breathing red by RN #6, Resident d about the same". with LPN #3 revealed that same in around 11:00 AM, ested the resident go to the ne called Physician #1, and ransfer the resident to the network that the resident to the network that is a proximately 11:00 at upon arriving to the unit, eresident breathing from the nember stated that she are go to the hospital for no documented evidence d the resident's physician is family member arrived to the record revealed a print completed at 12:12 PM, lent was having shortness of unds, labor or rapid Continued review revealed as facility notified Physician obtained an order to send	{F 5	580}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION ING		(X3) DATE SI	
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	ROVIDER OR SUPPLIER **POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP (200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE	1 03/	3012021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD B THE APPROPRI		(X5) COMPLETION DATE
{F 580}	have initiated increas and instructed the sta signs/symptoms of de status, or more likely for evaluation, especiexhibiting stridor. Cor Physician #1 revealed him with changes of deceived the ED staff assessed audible stridor, increasing accessory must wheezing to bilateral Resident #323's hosp resident was admitted Unit) at 10:54 PM. The Resident #323 with direction at 10:54 PM. The Resident #323 with direction of oxygen level). Interview with the Admit 48 PM and the Interview with the Admit 48 PM and the Interview with the resident a change of corbreathing occurred. In Director of Nursing and facility had no system residents' records to ephysician when a residents or that notification was appropriately. 3. Review of Resident	ne physician stated he would be monitoring of vital signs of to monitor for ecompensation of respiratory sent the resident to the ED ally if the resident was attinued interview with the expected staff to notify condition. 323's ED record revealed the resident to have sed respiratory effort, was cles to breathe and had mild lungs. Continued review of ital record revealed the to the ICU (Intensive Care en hospital admitted agnoses of Acute Hypoxic ney, Left Lower Lobe electasis (collapsed lung), ate level (results from low hinistrator on 08/10/2021 at im Director of Nursing on PM, revealed they expected lent's physician immediately addition, such as difficulty in addition, the Interimed Administrator stated the in place to monitor ensure staff notified the dent's condition warranted is being made timely and the resident on the stated the resident of the stated the resident of the stated the resident of the stated the resident	{F 5	(80)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING			1	R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 10 NURSING HOME LANE IKEVILLE, KY 41501	031	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 580)	(MDS) assessment dathe facility assessed to the facility and the facility and the facility and the facility assessment and the facility and the facility assessment and the facility and the facility assessment and the facility assessment and the facility assessment as the facility as the facility assessment as the facility assessment as the facility as the facili	d Protein-Calorie shagia. 90's Minimum Data Set ated 02/19/2021, revealed he resident to have a Brief status (BIMS) score of eight e resident had moderate The assessment stated the bounds. 90's comprehensive care 8/2021, revealed the facility had a potential for weight risk for malnutrition due to for eating, diagnosis of in B12 deficiency. 90's weight record revealed sident weighed 86.8 reflected a loss of 10.5% in r, there was no evidence the d of the resident's weight ered Dietitian's (RD) 04/09/2021, revealed the 90 had sustained a 8.8% s, and 10.5 % in 180 days. Resident #90's weight record 21, the resident's weight d on 06/15/2021, the 82.5 pounds. Review of the on 06/16/2021, revealed the weight loss in 30 days, a 90 days, and an 11.5 %	{F 5	80}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATÉ SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	,		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRINCE DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
{F 580}	revealed on 06/29/20 82.3 pounds. Review 07/07/2021, revealed resident had lost 13.1 loss in 180 days. Further review of Res revealed on 07/08/20 was 80.2 pounds. Observation of staff w 08/05/2021, revealed pounds. However, review of Resident #90's 17% v 167 days. 4. Review of Resident # assessment dated 03 facility assessed the re cognitively impaired. the resident complain swallowing. The facili be independent with re only, and weighed 20 Review of Resident #	sident #90's weight record 21, the resident weighed of RD documentation dated the RD documented the % in 90 days and 11.7% sident #90's weight record 21, the resident's weight reighing Resident #90 on the resident weighed 81.1 esident #90's medical 21 thru 08/05/2021, revealed by notified the physician of veight loss in approximately at #327's medical record dmitted the resident on hoses that included and Hyperlipidemia. 327's MDS admission /22/2021 revealed the resident to be severely The assessment also stated ed of difficulty or pain with ity assessed the resident to meals requiring set up help 5 pounds. 327's baseline care plan did an concerning Resident	{F 5	80}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R 20/2024
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501	09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 580}	revealed Resident #3 and the RD document sustained a 5% weight Review of the RD's do 04/09/2021, revealed #327 weighed 184.2 ploss of 10% in 30 day report revealed the RI the resident to the phyreview due to the facility cresident's intake was experience weight lost evidence the facility cresident weight lost evidence the facility cresident weight lost evidence the facility cresident weight lost evidence the facility cresident weight lost evidence the facility cresident weight lost evidence the facility cresident #327 on 05/07/2021, revealed #327 on 05/07/2021, weighed 182.5 pound documented the resident body weight in the particular weig	ration dated 03/26/2021, 27 weighed 194.2 pounds, ted the resident had at loss in one week. Documentation dated on 04/06/2021, Resident bounds, a significant weight s. Further review of the D recommended referring ysician for a medication lity's documentation that the "fair", but continued to is. However, there was no ontacted the resident's locumentation dated she evaluated Resident because the resident s on 04/27/2021. The RD lent had lost 6% of his/her st 30 days and 10.8 % of	{F :	580}			
	pounds.	A THE STATE OF THE	1				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		S 2	TREET ADDRESS, CITY, STATE, ZIP CODE OF NURSING HOME LANE PIKEVILLE, KY 41501	09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
{F 580}	record from 03/22/202 no evidence the facilit Resident #327's 17% approximately 136 da 5. Review of Resident revealed the facility at 05/12/2021 with diagr Disease, Alzheimer's Vitamin D Deficiency. Further review of Res revealed the resident on 05/12/2021. Review of Resident #4 assessment dated 05 resident was severely was independent with	esident #327's medical 21 thru 08/05/2021, revealed by notified the physician of weight loss in ys. It #82's medical record dmitted the resident on noses including Parkinson's Disease, Insomnia and ident #82's admission data is weight was 153.6 pounds 82's MDS admission /18/2021, revealed the cognitively impaired, but eating, requiring set up	{F 5	80}			
	weight was 148 pound in one week. Review of Resident #8 on 06/01/2021, the respounds, a 5.5 % weight Review of the RD assidentified Resident #8 weight loss in 30 days days. Continued review of Revealed on 06/08/202143.2 pounds.	ht loss in less than 30 days. essment dated 06/05/2021, 2 had sustained a 5.5 % 6, and a 13.4 % loss in 90 desident #82's weight record 21, the resident weighed ident #82's record revealed					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(AS) DAI		SURVEY		
		185256	B. WING			1	R /30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 200 NURSING HOME LANE PIKEVILLE, KY 41501)E	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD B E APPROPRIA		COMPLETION DATE
(F 580)	132.9 pounds on 08/0 loss of 13.4% in the last However, review of R record from 05/12/202 no evidence the facilities Resident #82's 13.4 % approximately 85 day 6. Review of Resident revealed the facility at 03/11/2020 with diagr Infarction, Diabetes M Aphasia. Review of Resident #05/12/2021, revealed resident to have a Bluindicating the resident Further review revealeresident to have swall residual food in his/hethe assessment revealeresident to require the (1) staff member at m stated the resident's w Review of Resident #05/12/2021, revealed potential weight concenteresident's diagnost the facility identified the body weight and was initiated on the care piphysician of significant Review of Resident #3	unds on 07/27/2021 and 03/3021, a significant weight ast 90 days. esident #82's medical 21 thru 08/05/2021, revealed by notified the physician of 6 weight loss in s. It #330's medical record dimitted the resident on loses that included Cerebral dellitus, Hemiplegia and 1330's MDS dated the facility assessed the MS score of four (4), it was cognitively impaired, and the facility assessed the owing difficulties and held are mouth. Further review of alled the facility assessed the elimited assistance of one eals. The assessment weight was 239 pounds. 330's care plan in place on the resident was at risk for erns/malnutrition because of its of Dysphagia. However, he resident was above ideal obese. Interventions lan included notifying the tree weight loss.	{F 5	80}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	185256	B. WING				R 09/30/2021	
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REH	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	03/	30/2021	
PREFIX (EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
dated 06/28/2021, reverthe resident had lost 16 in 180 days. Review of Resident #3 revealed the resident word Observation of Reside 08/05/2021, revealed the pounds. However, review of Resident from 05/12/202 no evidence the facility the resident's 12% wei 85 days. 7. Review of Resident revealed the facility re-04/03/2018 with diagnor Mellitus, GERD, and Comparison of Failure. Review of Resident #3 dated 03/01/2021 reversident to have a indicating the resident assessment also reveal independent with eating pounds. Review of Resident #3 the resident weighed 2 and 253.3 pounds on 0 However, review of Residence the facility no evidence the facility record from 03/01/202 no evidence the facility record from 03/01/202 no evidence the facility record from 03/01/202 no evidence the facility record from 03/01/202 no evidence the facility record from 03/01/202 no evidence the facility record from 03/01/202 no evidence the facility record from 03/01/202 no evidence the facility record from 03/01/202 no evidence the facility record from 03/01/202 no evidence the facility facility for the resident facility fac	eview of a RD assessment ealed the RD documented 0.6% of his/her body weight 130's weight on 08/03/2021, weighed 210 pounds. In the resident weighed 210 esident #330's medical 1 thru 08/05/2021, revealed or notified the physician of 19ht loss in approximately 1439's medical record eadmitted the resident on 15hronic Diastolic Heart 159's MDS assessment ealed the facility assessed BIMS' score of 15, was cognitively intact. The 19hronic Diastolic Heart 15hronic Diastoli	{F 5	880}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R
	ROVIDER OR SUPPLIER POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	1 09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 580}	revealed the facility at 03/12/2021 with diaground between the collection assessment at 5:39 PM, revealed 199.9 pounds and the inadequate to meet the Review of Resident # dated 03/19/2021, review of Resident with eating intact cogniassessment revealed independent with eating pounds. Review of Resident # revealed independent with eating intact cogniassessment revealed independent with eating pounds. Review of Resident # revealed independent with eating intact cogniassessment revealed independent with eating pounds. Review of Resident # revealed the resident 04/05/2021. Review of Resident # such thirty days. Review of Resident # revealed the resident # such thirty days.	t #332's medical record dmitted the resident on noses that included dney Disease, deflux Disease, dibrillation, and Femoral distance of 14 di	{F 5	880}	DEFICIENCY		
	Further review of Res	ident #332's weight record weighed 183.6 pounds on					

				DATE SURVEY COMPLETED			
		185256	B. WING_				R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501)DE		50/2521
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		ON SHOULD BE HE APPROPRIAT	E	(X5) COMPLETION DATE
{F 580}	However, review of R record from 03/19/20: no evidence the facilit the resident's 10% we 140 days. 9. Review of Residen revealed the facility re 09/30/2019 with Dem Major Depressive Dis Review of Resident # dated 05/18/2021, rev 117 pounds. Review of Resident # on 06/01/2021, the repounds. Review of a Resident #81, complet the resident sustained days and 8.9% weight Review of the RD's de #81 dated 07/07/2021 the resident's weight representing a 9.4% veriew of Resident # revealed the resident # revealed the resident # record from 03/19/202 no evidence the facility.	unds on 07/05/2021 and 03/2021. esident #39's medical 21 thru 08/05/2021, revealed by notified the physician of eight loss in approximately at #81's medical record e-admitted the resident on entia, Anemia, Anxiety and order. 81's MDS assessment realed the resident weighed the resident weighed sident weighed 109.2 RD assessment for the on 06/05/2021 revealed if a 6.5% weight loss in 30 those in 90 days.	{F 5	80}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING_				₹
NAME OF P	ROVIDER OR SUPPLIER	103230	D. 111110 _		TREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
		HABILITATION CENTER		20	00 NURSING HOME LANE IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 580}	PM and on 08/27/202 could recall being not to residents that had unable to recall speci stated he expected the to weight loss. Physician initiated Periactin (a mappetite stimulant) wheating and losing weigexpected staff to follophysician notification. Interview with the Ass Nursing/Interim Direct (ADON/IDON), on 08 revealed she had been for approximately one the IDON position and ADON/IDON stated serious the physician lost weight in the facil Interview with the Administrative with	an #1 on 08/04/2021 at 1:00 at 1:18 PM revealed he ified by staff at times related lost weight; however, he was fic dates or residents. He lee facility to follow its policy bothly and notify him of in #1 stated he usually nedication used as an inen a resident was not ght. He also stated he witheir policies related to in the facility. Sistant Director of tor of Nursing /18/2021 at 9:50 PM, en the ADON at the facility in the ADON at the facility in the ADON at the facility in the had never monitored and never monitored to was notified when residents lity. Ininistrator, on 08/11/2021 at 8/2021 at 3:30 PM, revealed allity's Administrator since in strator stated the facility and needs. She stated she rensure the residents' diviner the residents' diviner residents loss. She stated she was not had not been notified of the bould have	{F 5	80}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED			
		185256	B. WNG_			R 09/30/2021	
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		200	REET ADDRESS, CITY, STATE, ZIP CODE O NURSING HOME LANE KEVILLE, KY 41501		30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 580)	effective 09/26/2021: 1). Braden Scale Asson all residents by fact and comprehensive for were completed on all The facility utilized the and comprehensive for review and update can had pressure injuries 2). The wound care piles and pressure all pressure evaluated all current to the Medical Diagram of the Medical Diagr	essments were completed cility nurses on 08/28/2021 all body skin assessments I residents on 09/11/2021. Espaden Scale Assessment all body skin assessment to be plans of residents who by 09/17/2021. Thysician evaluated Resident taff assessed and enjuries, and staff reatments and reported birector/Physician #1 by 1021, upon admission a skin en Scale assessment will be baseline care plan will be ours to include any ential for pressure ulcer. A plan will be developed within to include pressure ulcers and include any ential for pressure ulcers. 15, #308, #309, #311, #314 and including a shower, nail lotion applied post shower, assing in clean appropriate as were placed on the 11/2021. The residents cial services on 09/15/2021.	{F 5	80}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		185256	B. WING_			R 9/30/2021		
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		9/30/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
{F 580}	by the Director of Nur New bath/shower sch by nursing staff to acc preference. Resident were obtained and in plans and State Regicare plans by the Regional Plans and State Regicare plans by the Regional reviewing all reference reviewing all reference recommendations for supplements to promany weight loss issue 7). All residents with and Chronic Obstruct (COPD), Asthma and by licensed nurse and with no concerns were 08/13/2021. 8). The Regional Nurwith orders for glucos and orders were ameentry of glucose value Administration Record (CDM) observed the lunch and dinner on 0 were delivered on time 10). Direct Care staffir recruitment efforts with provided through age Direct care nursing staffir care of the control of t	shower/hygiene preferences raing (DON) or designee. Redules were implemented commodate resident preferences for hygiene corporated into resident care stered Nurse Aide (SRNA) gional Nurse Consultant 9/13/2021. The Registered Dietitian (RD) residents' diets and made real changes or ote healing and to address residents. The diagnoses of Diabetes residents were assessed door Respiratory Therapist residentified completed reviewed all residents remonitoring by 07/30/2021 rended to include mandatory reson the Medication de (MAR). Tiffied Dietary Manager real service for breakfast, 09/11/2021, all three meals recommend was increased through	{F 58	30)				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B MANG		·		R
		105256	B. WNG			09/	30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE OO NURSING HOME LANE IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 580)	levels are adequate to residents. The staff won the unit at the staff won the unit at the staff Director of Nursing, N Administrator or design staff call offs will be requalified staff to see it and/or calling agencie qualified staff to fill the cannot be replaced the Assistant Director of Nursing management appropriate staffing lecenter will prioritize reachieved during emer required task including medication, no showe provided to incontinent that cannot turn self, it assist residents with restaffing levels have be meals are prepared a 12). On 08/11/2021, a #86 and #322, were reand physical forms of for Mental Status (BIN above and skin integribles be medicated Nurse. Residensed Nurse. Residensed Nurse. Residensed Nurse. Residensed Dementia had their Circulations.	inistrator to ensure staffing or meet the acuity of the ill be validated as present to feach shift by the sursing Supervisor, gnee. Direct care nursing eplaced by calling other if they can fill the opening, es to see if they have expening. If direct care staffing opening, or member of the team will fill the shift. If evels cannot be met, the esident care that can be regency staffing, prioritize gradministration of ers-sponge baths, care not residents, turn residents meals served timely, and meal if needed. Increased dietary staffing fforts and appropriate een achieved to ensure and delivered timely. Ill residents including #64, eassessed for psychosocial abuse with Brief Interview MS) score of eight (8) or ity reviews for residents with (8) were completed by dents with a diagnosis of are Plan reviewed and by the Minimum Data Set in 09/07/2021. No new red as indicating any	{F &	\$80}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		402250	D MANG			F	₹
		185256	B. WING			09/	30/2021
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
(F 580)	Continued From page	39	(F 5	580}			
	wandering risk assess 08/16/2021. All reside at risk for wandering I updated by the MDS identified active wand placed at each nursin potential interventions 14). Residents #39, # #332 were weighed b Registered Dietician (comprehensive nutriti recommendations we recommendations by (DON) or designee or DON or designee, spot Medical Doctor (MD) and recommendations entered into the electric the tray card. The Reguirector of Nursing (Din electronic medical record and tray card rinformation on 09/17/2015. Beginning 09/15/2015. Beginning 09/15/2015. Snacks to all residents afternoon by the restorates, or designee. So physician will be docuated, dietary aides and 16). The facility evaluated of compliance with C	g station with a list of a for nursing to reference. 65, #81, #90, #330 and y 09/17/2021. The RD) completed a on assessment and RD re reviewed for the Director of Nursing and validated the diet orders are reviewed for the Director of Nursing and validated the diet orders are reviewed for the diet orders are reviewed for the diet orders are reviewed by a reviewed by a reviewed by a reviewed by a reviewed by the restorative did or licensed nursing staff. The diet of the facility DC guidelines and red zones. The DON					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG_		·	R	
NAME OF RE	ROVIDER OR SUPPLIER	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		_		09/	30/2021
TO UNIC OF T	NOVIDER ON SOFFLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	W POST-ACUTE AND RE	HABILITATION CENTER	200 NURSING HOME LANE				
					PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
{F 580}	Continued From page	2 40	(F 5	80]	}) - "
	was designated with e	esidents and a yellow zone erection of a plastic zip wall (2) residents were moved to 21.					
	in the red zone on 08/ #328 and #329). Resi have completed quara physician orders. Res completed quarantine	per COVID-19 policy and sidents #311 and #314 were					
	COVID-19 on 09/16/2 identify any new case testing on 09/16/2021						
	surveillance testing as COVID-19. Positive C	s recommended for OVID-19 residents will be					
	droplet precautions w protective equipment. physician notification, plan revisions. The Donewly positive COVID isolation precautions taddition, any resident droplet precaution in if facility will provide phynotification and care pemployee testing protegionated days effect requires all staff must	The facility will provide family notification and care ON or designee will review 1-19 residents to ensure					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG	7.1	(X3) DATE SURVEY COMPLETED		
		185256	B. WING_			R 09/30/2021	
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 200 NURSING HOME LANE PIKEVILLE, KY 41501		333012021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
{F 580}	negative COVID-19 temployee will be test facility by the Infection designee. All testing posted to the employ common areas. 20). The facility screet for signs and/or symptocumented on the MRecord (MAR). The firmonitoring for signs a residents on 09/17/20 21). Resident #9, Reresident #326 and Rever eviewed for us administration times 109/23/2021. 22). The facility state their medication as on and implemented phanotification if any medication regarding to 123). The facility will abide physician regarding to 123. The facility with the the facility with a three medications that required for cost authorization 124). New admissions the facility after norm weekends will have designed to 125.	ee to work without a current est. During testing, the ed prior to entering the n Prevention Nurse or dates and times will be ee page, time clock and ens all residents once a shift otoms of COVID-19 and dedication Administration acility implemented and/or symptoms on all D21. Sident #321, Resident #324, esident #351, medications age and appropriate by the physician on If all residents will receive redered beginning 09/23/2021 armacy and physician dication was unavailable, by new orders from the he unavailable medication. Islated an agreement on facility's pharmacy to provide e (3) day supply of sires the facility's approval while pending cost review. and re-admissions entering all business hours and on lischarge orders submitted, ronic medical record and	(F 5	80}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		185256	B. WING			R 09/30/2021	
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE		(X5) COMPLETION DATE
{F 580}	fax transmittal as a batch pharmacy integration electronic medical recility the facility does not timely manner the phatch facility will utilize the facility will utilize the facility will utilize the facility will utilize the facility will utilize the facility will utilize the facility will utilize the facility will utilize the facility will utilize the facility of the physical substitution and/or new facility of all residents with the facility conduction facility by 09/25/2021. 26). The facility conduction facility process, and a ensure compliance with a daministrator over the Administrator over the QAPI committee Nursing, Administrator over the QAPI committee Nursing, Administrator on 09/1 current Administrator on 09/1 current Administrator will receive guidance from the Re Regional Director of Colinical Nurse for 30 of the thirty-day oversigned.	ty implemented the use of ackup to the electronic by entering the order in the cord to receive medications. The receive medications in a sarmacy will be notified, and the emergency medication rises and medication is ician will be notified for two orders. The Consultant, Director of the nursing staff completed an ordered medications and is were available in the formulation to the AOC and all audits. The resees the QAPI committee. Consists of the Director of the AOC and all audits. The resees the QAPI committee. Consists of the Director	{F 5	80}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R	
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE DO NURSING HOME LANE IKEVILLE, KY 41501	[09 <i>]</i>	30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 580}	responsibility to direct communicate areas of improvement. 28). The Administrator QAPI Committee revisions of Daily Livitimeliness of Daily Livitimeliness of meal traturning and reposition. 29). The Vice Preside Clinical Operations are Consultants conducted 09/15/2021 with a core consultation to review outcomes of the Survey roles of the Governing Rules and Regulation the following communification Control (CO staff at the facility to recare, prepare and discresidents with eating, effective Pharmacy S and neglect effectively appropriate ADLS, and QAPI committee. 30). The Administrator Consultant reviewed a beginning 09/16/2021 and/or revisions to the the 09/16/2021 meetic standardized plan to dereviewed as needed as	is direct oversight and it, discipline, and of concern and process or, Medical Director, and ewed procedures for a ll-ins, answering call lights, ang (ADL) Care, serving, and ys incontinence care and aing on 09/15/2021. International Nurse and a conference call on a the following: (1) the ey; (2) expectations and a glody as outlined in the ey; (3) determined a plan for a plan for a call on the following: (1) the ey; (2) expectations and glody as outlined in the ey; (3) determined a plan for a plan fo	{F &	80}				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R 30/2021	
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	ODE	007	00/2021	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE					(X5) COMPLETION DATE		
{F 580}	physical restraints, management, infectior readmission rate, rehisocial services, conceresident council, and grievances, admission development, vacant orientation, dietary value weight loss, work injuited employees on family absence, new hires, review, pharmacy repubusiness office, and a Committee and Medic standardized agenda but not limited to, the meeting. 31). The Regional Dir Vice President of Ope Administrator, the DO on 09/16/2021 regard Governing Body, incluprocedures to be implicated in the QAPI processes, the inthe QAPI processes, the inthe QAPI process, causes with the utilization approaches and, audic Calendar. The Administrator reports before each Coreovers before each Coreovers before each Coreovers and some process of the control of the core of the	ding tubes, contractures, edication usage, risk on control, hospital abilitation management, family council concerns, family council concerns, ans, discharges, census, staff positions, employee oriances, tray audit report, ries, terminations, medical leave, a leave of medical record compliance forts, restorative nursing, admission actions. The QAPI cal Director approved the fon 09/16/2021 to include, topics presented during the fector of Operations and ferations met with the fiveness of th	{F 5	580}				
	beginning 09/15/2021 compliance with the d	for review to ensure eficiencies cited during the						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	163236	0. WING	_	STREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
		HABILITATION CENTER		2	DO NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
{F 580}	09/10/2021 survey. O 09/16/2021 to discuss interventions to remo implemented QAPI m (4) weeks, as needed Administrator will forw minutes to the Govern including the Vice Preside Regional Vice Preside Regional Nurse Constresults. The QAPI constresults. The QAPI more review. The Administr Committee. The QAPI more committee. The QAPI more committee. The QAPI more committee. The QAPI more committee. The QAPI more committee. The QAPI more committee. The QAPI more committee. The QAPI more committee. The QAPI more committee. The QAPI more committee. The QAPI more committee. The QAPI more committee. The QAPI more committee. The QAPI more committee. The QAPI more committee. The QAPI more committee of QAPI. Tool Kit, QAPI more committee of QAPI. Committee of committee of committee of committee of QAPI. Committee of committ	API Meetings were held on a sabatement and develop we the jeopardy. The facility heetings weekly, times four it, and monthly. The ward all QAPI Meeting ning Body members, esident of Operations, and the sultant, to review the audit mmittee will review the eetings. Committee for rator oversees the QAPI PI Committee consists of the administrator, Medical ces Director, Activities, intenance, Dietary and hees. Body will provide the facility's sources and education heluding but not limited to the eat a Glance, and a resource and ency after one (1) year. The Governing Body will be upcoming year and help and the provide the frequency meetings to weekly for four eded effective 09/16/2021, of care is monitored and help and Federal requirements were educated by the MDS Coordinator, or	{F 5	580}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1, ,	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WING				₹ 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		031	50/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(= = = = = = = = = = = = = = = = = = =	SHOULD BE		(X5) COMPLETION DATE
{F 580}	changes to the Regist 09/17/2021. 36). On 09/13/2021, the Dietary Manager (CD Manager on the proving assessment to ensure diet order accuracy, a orders into the electron CDM educated the Direction of the nurse enters the control of the nurse enters the	he Regional Certified M) educated the Dietary sion of timely nutritional de diet order accuracy, on and on when to enter diet whice medical record. The dietary Manager to enter ato the tray care system. If dietary Manager to enter ato the dietary staff, ature. In the morning clinical wiew diet orders from the de accuracy. If education to all nursing desitioning range of motion, and from bed to chair and de on 08/19/2021 and do 021. The facility employed deal staff through recruitment ato ensure adequate staff to a residents who cannot designed the sector of Nursing educated dessure ulcer prevention, are positioning, adequate an, positioning devices, how ment a head-to-toe skin at to notify the registered	{F 5	580}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		185256	B, WING_			R 09/30/2021	
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 200 NURSING HOME LANE PIKEVILLE, KY 41501		09/30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD BE E APPROPRIA		
{F 580}	timely call light responsibility call light responsibility. The DON or defacility staff not working returning to work. 40). On 08/31/2021, The DON or defacility staff not working returning to work. 40). On 08/31/2021, The DON or defacility staff not working returning to work. 40). On 08/31/2021, The Don to the electronic meand interventions. In Director of Nursing edexisting care plan in the with new goals and in impairments identified the decironic meand interventions. In Director of Nursing edexisting care plan in the with new goals and in impairments identified the decironic meand interventions. In Director of Nursing edexisting care plan in the with new goals and in impairments identified the decironic meand in the decironic meand of the dec	gnee educated all staff on the inse. In addition, direct care is and certified nursing ided education on providing a resident's plan of care, and resident's plan of care, and residents in their choice timely delivery of meal signee will educate any and during education upon. The Regional Director of licensed nursing staff, the the Social Service Director, on entering new care plans dical record, including goals addition, the Regional lucated staff to update the the electronic medical record terventions for any new skin I during their shift. Piratory Therapist educated lentifying and assessing ge in respiratory status on in, on 08/12/2021, the DON lated all licensed nurses on otoms of lycemia, the facility's	(F 5	80)			
		ical staff on documentation 8/19/2021 and 08/20/2021 ervices.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		FIPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED	
		185256	B, WING		i	R 09/30/2021	
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZI 200 NURSING HOME LANE PIKEVILLE, KY 41501	IP CODE	03/30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
{F 580}	licensed nurses on complan with intervention diabetes and a respir hours of admission, recopy to the resident at Licensed nursing state education was notified will not be allowed to received this education 43). Beginning 08/12/staff on the facility's "call-off procedure for event a person needs dayshift, they are to no supervisor two hours. If staff needs to call of to notify their immediate before the start of the not have appropriate immediate supervisor other qualified staff to off. If emergency staff Administrator and/or of the start of the not have appropriate immediate supervisor other qualified staff to off. If emergency staff Administrator and/or of the start of the not have appropriate immediate supervisor other qualified staff to off. If emergency staff Administrator and/or of the start of the not have appropriate immediate supervisor other qualified staff to off. If emergency staff Administrator and/or of the start of the not have appropriate immediate supervisor other qualified staff to off. If emergency staff administrator and/or of the start of the not have appropriate immediate supervisor other qualified staff to off. If emergency staff administrator and/or of the start of the not have appropriate immediate supervisor other qualified staff to off.	/2021, the DON educated ompleting a baseline Care is and goals relevant to atory diagnosis within 48 eviewing and providing a and/or the responsible party. If not working during d of angoing education and work until they have on. // 2021, the DON educated all call off" procedure. The the facility included: in the ato call out of work for totify their immediate before the start of the shift. If on the night shift, they are sate supervisor four hours ir shift. If the facility does staffing levels, the and/or designee will call replace the person calling ffing is required, the	{F 5		engy)		
	working will be in-sen 44). All staff were pro-	viced upon return to work. vided re-education by the designee on 08/12/2021 on ving, preventing, and ell as identifying and ate interventions for vere educated by the IDS Coordinator, or					

	OF DEFICIENCIES CORRECTION	IDENTIFICATION AND ADDRESS.			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING			1	R
NAME OF P	ROVIDER OR SUPPLIER	100200	10. ************************************		STREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
PARKVIE\	V POST-ACUTE AND RE	HABILITATION CENTER		;	200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			IX ;	E ATE	COMPLETION DATE	
{F 580}	changes to the Regis 09/17/2021. On 09/13 the Dietary Manager itimely nutritional asse accuracy. When staff electronic medical recorder will send the writing order into the tray car review diet orders from clinical meeting to ended the control of the tray car review diet orders from clinical meeting to ended the control of the tray car review diet orders from clinical meeting to ended the control of the cont	ing, and reporting weight tered Dietician by 8/2021, the CDM educated on diet order accuracy and essment to ensure diet order enters diet orders into the cord, the nurse entering the litten communication to the stary Manager will enter the re system. The facility will me the previous day in the sure accuracy. OM educated the Dietary 21 on facility policy are times and the use of pes for those requiring re all meals meet the esidents in accordance with guidelines to reflect religious, eds of the population. In the Regional CDM with the dietary manager on ences, the facility's tray card based on menus, stocking anacks, and hydrations are scoop sizes, and/or tursing or Regional Director nurses and the Dietary ess for entering, activating, the registered dietician's	{F :	580)			
	DON and/or designee	by 09/17/2021 on the					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL' A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				₹ 30/2021
	ROVIDER OR SUPPLIER **POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 200 NURSING HOME LANE PIKEVILLE, KY 41501	IP CODE	007	0012021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED)			COMPLETION DATE
{F 580}	(PPE), yellow and red DON/designee educa monitoring residents f beginning. 08/12/202 educated all staff, incl were not working. Dur 08/12/2021, the Covid handwashing policy, or red and yellow zones, for signs/symptoms of reviewed. 50). Staff were provide 08/20/2021 by the DORegional Nurse Consistymptom monitoring of admissions into the reducated on the five (administration, including patient, right dose, rig Regional DON/DON/olicensed nursing staff the process to follow wavailable for administred ducation included cathe medication, obtain medication delivery time ordered medication with outside of the ordered education also included given by the MD, doct and new orders from the medical record. All other medical record. All other medical record.	elines, handwashing, anal Protective Equipment I zones. In addition, the ted, licensed staff on or Covid-19 symptoms 1, the DON/designee luding contract staff, who ring the QAPI meeting on II-19 policy, the donning and doffing PPE, and monitoring residents of the Covid-19 were led re-education on the Covid-19 were led re-education on the Covid-19 were led re-education on the Covid-19 were led re-education on the Covid-19 were led re-education on the Covid-19 were led re-education on the Covid-19 were led re-education on the Covid-19 were led re-education on the Covid-19 were led re-education on the Covid-19 were led re-education on the Covid-19 were led re-education on the Covid-19 were led re-education, right led right medication, right led right medication, right led right medication, right led right medication was not ration as ordered. The lling the pharmacy to obtain thing the anticipated	{F 5	80)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUC	(X3) DATE SURVEY COMPLETED		
		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER			RESS, CITY, STATE, ZIP CODE G HOME LANE KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD B COSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
{F 580}	Consultant educated including new hires are use of the emergency in place for ensuring a notifying the physician re-admitting residents after-hours. 53). The Interim Admit on his contact information Coordinator from 09/1 In addition, education who to notify if unables shift. 54). The facility will are head-to-toe skin asset through Friday, for the 09/17/2021 to ensure weekly on each reside will notify the physicial Responsible Party of and those new interverplace to prevent decliping t	the DON /Regional Nurse all licensed nursing staff, and/or agency staff, on the medication kit, the system medications are in-house, or a for new orders for new or a, including on weekend and finistrator educated all staff ation and role as the Abuse 13/2021 through 09/17/2021, on staffing schedules and a to work their scheduled and weekly resident essments daily, Monday ree (3) months effective they have been completed ent. In addition, the facility an, Registered Dietician, and any new skin impairment entions have been put in the control of the control	{F 5	80}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY
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		185256	B. WING			09/	30/2021
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	N POST-ACUTE AND RE	HABILITATION CENTER	200 NURSING HOME LANE		200 NURSING HOME LANE		
					PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	(X5) COMPLETION DATE
{F 580}	Continued From page	÷ 52	{F 5	80	}		
		ent identified had a care nclude new interventions.					
	rounding of residents incontinence, and res residents will be visual shift daily for two (2) we residents each shift for twenty-five percent of (4) weeks. The facility to 6:00 PM and 6:00 F 58). On 09/11/2021, the began visual monitorial response times, including that are answered, a staff will conduct ten (each shift for two (2) we light observations each 59). On 08/13/2021, the	r designee began visual assessing hygiene, toileting, ident repositioning. All ally rounding on once each weeks, fifty percent of the property for four (4) weeks, and residents each shift for four (4) has two (2) shifts, 6:00 AM PM to 6:00 AM. The facility's leadership staffing and timing of call light ding the length of time call across all shifts. Leadership (10) call light observations weeks and then five (5) call the shift for eight (8) weeks. The DON and/or Designee piratory assessments and					
	Recommendation (SE acute change in respi	BAR) communications for ratory status Monday clinical morning meeting.					
	respiratory status for l implementation of any Plans were reviewed	Physician notification and physician order. Care and updated as needed. one (1) week, then five (5)					
	began audits on 09/15 completion for all new	DON, and/or Designee 5/2021 of baseline care plan r admissions and ure staff completed the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		185256	B. WING_			R 09/30/2021	
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 200 NURSING HOME LANE PIKEVILLE, KY 41501		373072021	
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE	
{F 580}	61). All residents adni days with a diagnosis Obstructive Pulmona Asthma, or current Procare Plan reviewed athe MDS Nurse(s) an interventions will be a morning meeting by the nursing designee. 62). Beginning on 08. DON, and/or Designer admissions and re-accare plans for complewith the resident and variance or identified immediately. Audits with the facility for four admissions for a weethen ten percent of accare plans for complewith the facility for four admissions for a weethen ten percent of accare plans to residen All three (3) meals with a change in responsible of identification according to the facility for two all three (3) units dail (1) meal on all three weeks. 64). On 08/15/2021, began audits of staff quiz of identification according to the process of the facility of identification according to the process of	ithin 48 hours of admission. nitted within the last thirty of Diabetes, Chronic ry Disease (COPD), neumonia had their baseline and updated as needed by d/or designee. New added to the care plan in the he DON, ADON, and/or	{F 5	80}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I INFINITIFICATION NUMBER		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 200 NURSING HOME LANE PIKEVILLE, KY 41501	E		30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATÉMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE		(X5) COMPLETION DATE
{F 580}	change in a resident's physician and followir Leadership will quiz s shifts; ten (10) staff for staff a week for four (4) staff a week for four (5). On 08/13/2021, the began monitoring all of results Monday through morning meeting. The any blood sugar result range for MD notificat any Physician's Order reviewed and updated designee will complet diabetic residents acric (3) units to identify an signs and symptoms of hypoglycemia/hyperginesident was immediated one (1) week, then fiv (4) weeks. 66). On 08/13/2021, the designee implemented questionnaire on abust residents with wander the proper reporting of units. The employee completed for five (5) then three (3) times a and then weekly for for identified concerns immediately.	protocol, documenting a condition, notification of the ag physician's orders. taff randomly across all or one (1) week and five (5) (4) weeks. The DON and/or Designee documented blood sugar gh Friday in the clinical e DON/designee will review its outside of the normal ion and implementation of its. Care plans will be it as needed. The DON or it is a needed. The DON or it is a needed in a needed identifies and all three by resident with apparent of bycemia to ensure the itely assessed by licensed identified concerns will be ly. Audits will be daily for it is a week for four the Administrator and/or dan employee is and identification of ing behavior to determine if abuse across all shifts and questionnaire will be staff daily for one (1) week, week for two (2) weeks, our (4) weeks. Any variance	{F 5	580)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	8. WING				R 30/202 1
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 100 NURSING HOME LANE PIKEVILLE, KY 41501	037	30/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 580}	admission and quarte Set (MDS) assessme wandering will be disc morning meeting to re interventions. Any var will be addressed imm will be care planned in the Director of Nursing, or nursing de 68). Beginning on 08/Services Director or drandom interviews of of eight (8) or greater the facility and have now itnessed abuse. The review random weekly residents with a BIMS to ensure no injuries of 08/13/2021. Any variation will be addressed imm 69). On 08/25/2021, the conducted audits of reflectronic medical region the diet/tray card so 70). Beginning on 08/Manager will ensure a kitchen and reaching be conducted for randone (1) week, twice pland then weekly for o trays arrive at the unit assist in passing trays meal trays, and certifications.	nee will review each risk assessment upon rily with their Minimum Data nt. Any resident identified as cussed in the clinical eview and initiate new riance or identified concerns nediately. New interventions in the morning meeting by g, Assistant Director of resignee. 13/2021, the Social residents with a BIMS score residents with a BIMS score residents with a BIMS score residents with a BIMS score residents with a BIMS score residents with a BIMS score residents with a BIMS score residents with a BIMS score residents with a BIMS score residents with a BIMS score residents with a BIMS score resident swith a BIMS	{F 5	80}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		S 2	TREET ADDRESS, CITY, STATE, ZIP CODE ON NURSING HOME LANE PIKEVILLE, KY 41501	09/	30/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 580}	trays to residents after beginning 09/11/2021 observed on each unit two (2) meals on each weeks, one (1) meal of weeks. 71). The dietary mana admitted/re-admitted beverage preferences admission and enter the system for listing on the completed bi-annually residents. Physician-be audited by the Diet (1) week, weekly for fafter that for four (4) in 09/15/2021. 72). Daily COVID-19 saudited beginning on Resources (HR) Direct punches to ensure so their shift. Audits will be through Friday for fou Director, and weekends staff not screened will immediately on the COV Nurse, an infection condoors will remain lock.	e time it takes to pass meal r they arrive on the unit . All three (3) meals will be t daily for two (2) weeks, n unit daily for two (2) on each unit daily for four (4) ager or designee will review residents' food and s within 72 hours of them into the diet/tray card neir tray cards beginning of food preferences will be and as needed for all ordered snack intakes will tary Manager daily for one our (4) weeks, and monthly nonths beginning screenings for staff will be 08/25/2021 by the Human ctor against time clock reening before beginning be completed Monday r (4) weeks by the HR ds audited on Mondays. Any be re-educated OVID-19 Screening Policy	(F 5	80}			
		17/2021, the DON and/or even (7) times each week				•	

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WING_			R 19/30/2021	
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
{F 580}	(4) weeks to audit infidiffering shifts and unobservation of handwand zones; donning/opPE; and mask compidentified concerns who the auditor. 74). The DON, ADON review all residents opharmacy to ensure a beginning 09/23/202 physician within two expiration. 75). The Regional Numedication pass observation pass observation pass observation of twenty accuracy of medication concept of twenty. Administration to concept open pass observation of twenty. Friday, the DON, ADON audit medication delimedications daily to eneeding a renewal hapharmacy. Audits will Immediate Jeopardy. Beginning 09/11/and/or DON will be residential and and and and and and and and and and	ve (5) times weekly for four ection control compliance on hits. Audits will include vashing; isolation signage doffing (putting on/taking off) poliance. Any variance or will be addressed immediately of the anactive script is on file of the control of the prescription's of the prescription of the prescriptio	{F 5	80}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WING_			R	
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	DDE	1 09/3	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIA	E NTE	(X5) COMPLETION DATE
{F 580}	78). Beginning 09/11/Dietary Manager will I dietary staffing daily for adequate staffing. 79). Beginning 09/11/President of Operation monitor and audit the days to ensure complete to ensure complete to ensure complete to ensure complete to ensure complete to ensure complete to ensure complete to ensure complete to ensure complete to ensure complete to ensure complete to ensure complete to ensure complete to ensure the facility to ensure the facility to or witnessed abuse concerns. Interviews to conducted of resident designees weekly untremoved. **The State Survey agactions to remove the 09/26/2021 as alleged 1). Review of Head-to revealed staff assessed on 09/11/2021. A revier evealed eight (8) resident (8) resident (9/11/2021) as alleged 1). Review of Head-to revealed eight (8) resident (9/11/2021) as alleged 1). Review of Head-to revealed eight (8) resident (9/11/2021) as alleged 1). Review of Head-to revealed eight (8) resident (8) res	2021, the Administrator and be responsible for reviewing or four (4) weeks to maintain 2021, the Divisional Vice and and/or designee will Administrator daily for 30 iance. Will be conducted beginning a for residents' change of atton of need for "Stop and andition) communication. 2021, the Administrator or anterviews of residents with a 33 or greater to ensure they and had not been subjected and had not been subjected and had not been subjected and had not be so by the Administrator or all immediate jeopardy is gency validated the facility's Immediate Jeopardy on I by: -Toe Skin Assessments and all residents in the facility are of the skin assessments dents (Residents #65, #27, #74, and #358) had so with a total number of the plans for Residents #65,	⟨F 5ℓ				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	ODE	1 03/	5072521
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	· · · · · · · · · · · · · · · · · · ·	ION SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE
{F 580}	facility completed the A review of the facility revealed staff assesse pressure ulcers with the with the Regional DO revealed she complet assessment on all res further revealed that the (20) total pressure injust the facility completed assessments on all res Continued interviews Interdisciplinary Team assessments and Braupdate the residents' Resident #65, #324, # and #358's care plans current pressure injust with MDS Nurse #1 or revealed she updated reflect current pressure addition, she complete rounds on 09/15/2021 the Registered Dietici DON, and the MDS N #324, #45, #14, #357 review revealed the In reviewed each resident's orders care plan, and implem 2). Review of Resider revealed the Medical resident on 08/25/202 Stage four (4) pressur deep tissue injury (DT	pressure injuries. The review on 09/17/2021. 's census on 08/28/2021 and all residents at risk for the Braden Scale. Interview N on 09/30/2021 at 4:17 PM and the Braden Scale stated that the Braden Scale stated that the Braden Scale stated that the Braden Scale stated the utilized the skin den Scale assessments to care plans. She stated that the Habitan Scale assessments to care plans. She stated that the stat	(F 5	i80}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		SURVEY
		185256	B. WNG				R
NAME OF P	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
PARKVIE	N POST-ACUTE AND RE	HABILITATION CENTER			200 NURSING HOME LANE		
					PIKEVILLE, KY 41501	_	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 580)	Continued From page	e 60	{F 5	580	}		
{F 580}	Resident #65's wound 08/26/2021 at 9:00 Al wound measured, "13 12.3 cm width and 0.2 at 10 o'clock measurin 12 o'clock that measurin 12 o'clock that measurin 12 o'clock that measuring 12 o'clock that measuring 12 ordinued to treat the ulcer with Aquacel Ag evaluation completed Resident #65 had six including a stage two measuring 1.2 cm (ler 0.1 cm (depth), stage measuring 2.5 cm by stage two (2) to left hi cm x less than 0.1 cm scapula measuring 1 on 1 cm, unstageable to cm by 0.6 cm. and for measuring 12 cm by 1 Interventions in place heel protectors while i weekly documentation mattress to bed, nutrit turning/repositioning. For the sacral pressures 10:21 AM revealed the by 11 cm by 0.3 cm widrainage and 95 perceits.	d care note dated M, revealed the sacrum C cm (centimeter) (length) by C cm depth with undermining Ing 2 cm and undermining at Ires 1 cm, muscle exposed. It is present, partially cleanser." The facility resident's sacral pressure I have review of a wound on 09/15/2021 revealed (6) pressure ulcers, (2) to the left superior calf Ingth) by 1.4 cm (width) by one (1) to the right hip C cm by less than 0.1 cm, I measuring 1.2 cm by 0.8 I stage two (2) to left I cm by 0.2 cm by less than o right heel measuring 0.6 In (4) areas to the sacrum I1.6 cm by 0.4 cm. In of the resident included In bed, diet as ordered, In of the wound, an air I ional supplements, and Observation of wound care I wound measured 13 cm I ith a scant amount of I ent granulation tissue.	{F 5	580)			
	observation of other p	would not consent to the ressure areas. A medical					
		d that on 09/21/2021 at 2:19					
	PM, Physician #1 dete						1
		ds were unavoidable. On					
	09/28/2021, Resident						
		visits. Further review of the //29/2021, staff notified the					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		185256	B. WING_				R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP (200 NURSING HOME LANE PIKEVILLE, KY 41501	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD B THE APPROPRI		(X5) COMPLETION DATE
{F 580}	with no new orders. T with Failure to Thrive. 3). The facility admitte 09/10/2021, complete 09/10/2021, complete 09/10/2021, and compon 09/10/2021. Resid 09/25/2021 and re-ad 09/28/2021. Further or revealed staff develop plan on 09/21/2021. A re-admission revealed admission skin asses 09/28/2021, Braden 5 baseline care plan de 4). Observation of Re 1:48 PM, Resident #308 on Resident #309 on 09/Resident #311 on 09/Resident #314 on 09/Resident #320 on 09/revealed the residents well-kempt, and clean residents' beds. Interview during the time of the identified concerns. A for Residents #45, #6 and #320) revealed the Director interviewed thand had no concerns Interview with the ISS revealed she interview #308, #309, #311, #3	the in the resident's wound the resident was diagnosed and Resident #355 on and a skin assessment on a Braden Scale on pleted a baseline care plan ent #355 was discharged on mitted to the facility on eview of the medical record and the comprehensive care a review of Resident #355's at the resident had an sment completed on Gale on 09/28/2021, and a veloped on 09/28/2021 at 1:40 an 09/28/2021 at 11:10 AM, 29/2021 at 11:52 AM, 29/2021 at 11:52 AM, 29/2021 at 11:30 AM and 29/2021 at 11:30 AM and 29/2021 at 11:30 AM and 29/2021 at 11:30 AM and 29/2021 at 11:30 AM and 29/2021 at 11:30 AM and 29/2021 at 11:30 AM and 29/2021 at 11:30 AM and 29/2021 at 11:30 AM and 29/2021 at 11:30 AM and 29/2021 at 30 AM and	{F 5	(80)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	FIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		185256	B. WNG				R 30/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	ZIP CODE	03/	3012021
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER		200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION E ACTION SHOULD BI D TO THE APPROPRIA CIENCY)	_	(X5) COMPLETION DATE
{F 580}	on 09/28/2021 from 1 no identified concerns reviews revealed Res #309, #311, #314, an shower preference are obtained and included review of the resident the comprehensive caplan, revealed staff upto reflect the resident the Vice President of at 4:10 PM revealed resident preferences. was interviewed for spreference, and the faresident's care plan. Interviews revealed the preference was obtain shower schedule reveshower/hygiene preference with the 3:53 PM revealed she resident diets on 08/2 that she implemented recommendations for loss and/or wound he documentation reveareviewed all residents DON reviewed all die Interview with the RD revealed she complete and recommendation 7). A review of facility 08/13/2021 revealed	sidents during the initial tour :33 PM to 2:32 PM revealed s. Interviews and record sidents #45, #65, #308, d #320 each had their and hygiene preference d on their care plan. A 's medical record, including are plan and SRNA care potated each resident's plan is preference. Interview with Operations on 09/30/2021 she assisted with obtaining She stated each resident hower and hygiene acility updated each A review of resident heir shower/hygiene hed. A review of the facility's ealed that the resident erences were honored. Dietician on 09/30/2021 at the began reviewing all taling. A review of the led the Registered Dietician the diets, and the Regional ts and recommendations. O on 09/30/2021 at 4:17 PM ted the review of all diets s. assessments completed by thirty-nine (39) residents abetes were assessed for	{F 5	80)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		185256	B. WING_		<u> </u>	1	R 30/2021
	ROVIDER OR SUPPLIER ** POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CI 200 NURSING HOME PIKEVILLE, KY 41	ELANE	<u> USI</u>	50/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 580}	09/30/2021 at 4:17 Pl the residents and did concerns. Observatio 09/28/2021 at 1:36 Pl 09/29/2021 at 11:35 A 09/29/2021 at 11:52 A signs/symptoms of hy A review of facility as 08/12/2021 revealed diagnosis of Chronic Obsorder (COPD), Ast assessed by Respirat with Respiratory Ther at 12:45 PM revealed with diagnoses of Chronic Observation of Resident Hollows (COPD), Ast 08/12/2021 with no id Observation of Resident Hollows (COPD), and Resident Holl	e need for immediate with the Regional DON on If revealed she assessed not identify immediate ns of Resident #348 on If, Resident #320 on If, Resident #320 on If, Resident #311 on If, Resident #311 on If, Resident #311 on If, Resident #311 on If, Resident #311 on If, Resident #311 on If, Resident #311 on If, Resident #311 on If, Resident #311 on If, Resident Resident with a If, Residents with a If, Residents with a If, Residents with a If, Residents with a If, Residents with a If, Resident Residents If, Resident Residents If, Resident Residents If, Resident Residents If, Resident Resident If, Resident Resident If, Resident Resident If, Resident If	{F 5	30}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		200	REET ADDRESS, CITY, STATE, ZIP CODE 0 NURSING HOME LANE KEVILLE, KY 41501	001	50/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 580)	with the Regional Cer (RCDM) on 09/28/2020 09/30/2021 at 1:52 Pl observed on 09/11/20 within five (5) to ten (scheduled times. 10). A review of the factory of factory o	delivered timely. Interview tified Dietary Manager 21 at 2:26 PM, and M revealed lunch was 221 and arrived at the unit 10) minutes of the acility's staffing for AM to 6:00 PM revealed as and three (3) nursing duled for each floor of the e facility's staffing revealed as and two (2) certified and two (2) certified areach floor from 6:00 PM to a for 09/29/2021 and two (2) licensed nurses, and sing assistants on each floor PM. Further review of (1) licensed nurse and two ssistants for each floor from a staffing on 09/28/2021 from a staffing on 09/28/2021 from a staffing on 09/28/2021 from a staffing on 09/28/2021 from a staffing on 09/30/2021 from a staffing on 09/29/2021 and the baths/showers, was being conducted timely, bassed timely.	{F 5	80}			

AND DIAM OF CORRECTION I INCOMPRIGATION IN THE PROPERTY OF THE		(X3) DATE SURVEY COMPLETED				
		185256	B, WNG_			R 09/30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER	*	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		0010072027
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PERCEPTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECT) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE DEF			OULD BE	(X5) COMPLETION DATE
{F 580}	and 09/30/2021 at 1::09/30/2021 at 12:50 f at 10:31 AM; State Rd (SRNA/certified nurse 3:40 PM; SRNA #11 SRNA #7 on 09/29/20 on 09/29/2021 at 4:10 09/29/2021 at 3:04 Pl at 3:17 PM and SRN/ PM, revealed staffing staff member revealed duties as assigned. 11). Review of the sta 09/28/2021, 09/29/20 revealed each day co one (1) evening cook, day aides, and two (2 Observation of the kit PM reflected the staff schedule. Interview w at 1:12 PM, and Dieta 2:10 PM revealed kito	on 09/29/2021 at 3:00 PM 64 PM; LPN #10 on PM, LPN #11 on 09/30/2021 egistered Nurse Aide aide) #1 on 09/29/2021 at on 09/29/2021 at 3:23 PM; l21 at 3:29 PM; SRNA #19 DPM; SRNA #21 on M; SRNA #22 on 09/29/2021 A #23 on 09/29/2021 at 4:10 had improved, and each d they had time to perform ffing schedule for 21, and 09/30/2021 nsisted of one (1) day cook, one (1) prep cook, two (2)	{F 58	30}		
	conducted for Reside 08/11/2021. No concerview of skin assess no identified concerns interviews conducted and 09/30/2021 revea with psychosocial and including observations and #322. Interview w	other abuse symptoms was ints #64, #86, and #322 on erns were identified. A ments completed revealed is. Observation and on 09/28/2021, oled no identified concerns l/or physical abuse, is of Residents #64, #86,				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY
		185256	B. WNG_				R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		03/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
(F 580)	o9/30/2021 at 1:39 Pt a diagnosis of Demerreviewed and revised with the RDON on 09 revealed she complet 08/11/2021, for all res of licensed nursing staidentified. A review of Social Service Director BIMS score of eight (Videntified concerns. 13). A review of assess wander, revealed all research nursing station of binder on each floor thincluding a description interventions for each 14). Review of Reside and #332's medical reresidents had been with the Reg 09/30/2021 at 3:53 Pt comprehensive nutrition Residents #39, #65, #Review of the medical completed a comprehensive nutrition Resident #81, 09/16/2021 for Reside Resident #81, 09/16/209/16/2021 for Reside recommendations madischarged. Interview Dietician on 09/30/2020	with MDS Nurse #1 on of revealed all residents with thia had their care plans as necessary. Interview /30/2021 at 4:17 PM ed skin assessments on idents, with the assistance aff. No concerns were audits completed by the or (SSD) for residents with a street of the property of the or (SSD) for residents with a street of the property of the or (SSD) for residents that esidents had received a sment by 08/16/2021. The property of th	{F 5	80)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	_ I ' '	TIPLE CONSTRUCTION		(X3) DATE	SURVEY
		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER **POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 200 NURSING HOME LANE PIKEVILLE, KY 41501	ODE	109/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE
(F 580)	DON #2 on 09/30/202 resident had received assessment and revie by nursing staff. Furth and Regional DON retray card were review information. 15). Observation of that 2:22 PM, the fourth PM and the fifth floor revealed snacks incluoatmeal pies, goldfish drinks were present, i juice. Observations or revealed snacks were Review of Resident # Resident # 14's recordintake of snacks. Interesident # 14's recordintake of snacks. Interesident # 14's recordinate on document 16). Observation of the yellow zone on 09/29/2021 at 4:10 Pf educated on document 16). Review of Resident # 17). Review of Residents guidance. Observation 09/29/2021 at 11:41 A 8/30/2021 at 10:36 Af or symptoms of COVI been discharged from 18). Review of facility staff working on 09/16	30/2021 at 4:17 PM and 21 at 3:20 PM revealed each a comprehensive nutritional ew of the recommendations are interview with the RD wealed both the record and ed to reflect accurate the third floor on 09/28/2021 at 2:00 on 09/28/2021 at 2:06 PM ding but not limited to crackers, cookies and including soda, milk, and in 09/29/2021 at 10:30 AM is being passed on third floor. 331, Resident #65 and if revealed documented review with SRNA #19 on M revealed she was intation of snacks. The zones contained no sents #327, #328 and #329 on M revealed no obvious signs D-19. Resident #327 had	{F 5	(80)			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY
	į	185256	B. WNG_				R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		031	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFIX TAG		HOULD BE		COMPLETION DATE
{F 580}	at 1:39 PM, MDS Nur PM, Maintenance Ass 2:56 PM, Therapy Ma 1:18 PM, Housekeepi 09/30/2021 at 1:24 PM Director (HR) on 09/3 Marketing Liaison on Medical Records on 0 Central Supply on 09/29/2021 at 11:512:58 PM, RN #4/Woi 09/30/2021 at 2:54 PM 12:44 PM, LPN #7 on 09/30/2021 at 1:54 PM at 12:50 PM, LPN #11 AM, SRNA #1 on 09/2 #11 on 09/29/2021 at 09/29/2021 at 09/29/2021 at 3:29 PM at 4:10 PM, SRNA #2 SRNA #22 on 09/29/2 #23 on 09/29/2021 at 09/29/2021 at 1:12 PM 09/30/2021 at 2:10 PM Director/Dietary Mana 1:30 PM revealed the (2) times weekly. Inter Control Nurse on 09/3 she was conducting the following CDC guidant tested revealed tested times weekly.	ting for COVID-19 on no new cases. OS Nurse #1 on 09/30/2021 se #2 on 09/30/2021 at 1:31 sistant #1 on 09/30/2021 at mager on 09/30/2021 at mager on 09/30/2021 at mager on 09/30/2021 at no Supervisor on M, Human Resource 0/2021 at 10:48 AM, Senior 09/30/2021 at 10:55 AM, 19/29/2021 at 8:34 AM, 29/2021 at 2:40 PM, RN #1 15 AM and 09/30/2021 at 10:55 AM and 09/30/2021 at 10:30 PM and M, LPN #6 on 09/30/2021 at 10:31 10:30/2021 at 3:40 PM, SRNA 3:23 PM SRNA #7 on M, SRNA #19 on 09/29/2021 1 on 09/29/2021 at 3:04 PM, 021 at 3:17 PM and SRNA 4:10 PM, Cook #3 on M, Dietary Aide #3 on	{F 5	580)			
	resident had COVID-1						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	0.0	IPLE CONSTRUCTION		SURVEY
		185256	B. WING			R / 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STAT 200 NURSING HOME LANE PIKEVILLE, KY 41501	E, ZIP CODE	 3012021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECT) CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD B ED TO THE APPROPRIA FICIENCY)	COMPLETION DATE
(F 580)	monitoring as ordered 21). Interview with the 09/30/2021 at 3:25 PN Resident #321, Resident #351's in for usage and appropriate physician on 09/2022). Observation of a 09/29/2021 at 4:35 PN 09/30/2021 at 4:35 PN dentified concerns with addition, observation of floor on 09/30/2021 at identified concerns. In 09/29/2021 at 11:55 APM, N #4/Wound Care 2:54 PM, LPN #6 on 0 LPN #7 on 09/29/2022 09/30/2021 at 1:54 PN	ion, review of each led staff was completing the led staff was completing the led staff was completing the led staff was completing the led staff was completing the led staff was completed in the led staff was complet	{F 5	80}		
	at 3:11 PM revealed be agreement that the phefacility with a three-day requiring cost review. I pharmacy agreement requiring a cost review the facility a minimum medication while being	1021 at 4:10 PM and of Pharmacy on 09/30/2021 oth parties made a formal armacy will supply the y supply for medication Review of the facility's revealed for any medication of the pharmacy would send of a three-day supply of the				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l ' '	TPLE CONSTRUCTION		(X3) DATE	SURVEY PLETED
		185256	B. WING		-		R
NAME OF P	ROVIDER OR SUPPLIER	100200	D. 111110	STREET ADDRESS, CITY, S	STATE ZIP CODE	09/	30/2021
PARKVIE	V POST-ACUTE AND RE	HABILITATION CENTER		200 NURSING HOME LAN PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORR	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 580}	Director of Operations the Vice President of signed the agreement 24). Interview with RN AM and 09/30/2021 at 09/30/2021 at 2:54 PM 12:44 PM, LPN #7 on 09/30/2021 at 1:54 PM at 12:50 PM, LPN #11 revealed they had recaware of the process from the pharmacy. In they were aware that physician if the pharm medication to the facil 25). Interview with the on 09/30/2021 at 4:17 PM completed of all reside and verified all medicafacility by 09/25/2021.	nacy within 72 hours. The sof Guardian Pharmacy and Operations of the facility I #1 on 09/29/2021 at 11:55 t 12:58 PM, RN #4 on M, LPN #6 on 09/30/2021 at 09/29/2021 at 3:00 PM and M, LPN #10 on 09/30/2021 on 09/30/2021 at 10:31 AM eived education and was for obtaining medications addition, they revealed the nurse would notify the acy could not deliver a	{F 5	80}			
	and 09/30/2021 at 8:0 concerns with missing 26). Review of a QAPI the facility conducted with the Regional DON Consultant, Human ReRecords, the Houseke Supply, MDS Nurse #	9 AM revealed no identified medications. I signature sheet revealed a meeting on 08/12/2021 N, Regional Nurse esources, SSD #2, Medical eping Supervisor, Central 1, MDS Nurse #2, the Admissions Coordinator, Activities Director, the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		(X3) DATE COMP	SURVEY
		185256	B. WING				R 30/2021
PARKVIE	ROVIDER OR SUPPLIER N POST-ACUTE AND RE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		031	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		HOULD BE		(X5) COMPLETION DATE
{F 580}	09/13/2021. Further in Operations revealed shadministrator with dai 09/10/2021. 28). Interview with the 09/30/2021 at 3:40 PM 09/30/2021 at 3:25 PM committee, including the Consultant on 09/30/2 procedures for contact answering call lights, adelivering meal trays that the operations on 09/30/2 and turning/reposition 09/15/2021. 29). Interview with the Operations on 09/30/2 Nurse Consultant on 0 the Med-Net Concepts 09/28/2021 at 3:00 PM conducted a conferent following: (1) the outcommunication and roles outlined in the Rules and determined a plan for communication/monitor and COVID-19 isolation facility to monitor/assereposition residents, prepare and distribute residents with eating, effective Pharmacy Sereposition Page 10/20/20/20/20/20/20/20/20/20/20/20/20/20	e Vice President of 2021 at 4:10 PM and rim Administrator on of revealed the facility Interim Administrator on otherview with the VP of the had provided the Interim by oversight since Interim Administrator on of the Medical Director on of and members of the QAPI the Regional Nurse 2021 at 3:40 PM, revealed ting staff for call-ins, ADL Care, serving and imely, incontinence care ing were reviewed on of the Vice President of 2021 at 4:10 PM, Regional 29/30/2021 at 3:40 PM, and so Nurse Consultant on of the survey, (2) so of the Governing Body as and Regulations, (3) the following oring tools: Infection Control on, enough staff at the less residents, turn and rovide incontinent care,	{F 5	[80]			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE ·	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE 10 NURSING HOME LANE KEVILLE, KY 41501	037	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION;		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
{F 580}	QAPI committee. 30). Interview with the 09/30/2021 at 3:40 PI Consultant on 09/30/2 reviewed and revised presented the reviewed Committee during the facility developed a stall topics were review meetings. The plan in Foley catheters, entercontractures, physica usage, risk management, social signification of the plan in Foley catheters, entercontractures, physica usage, risk management, social signification of the properties of the properties of the properties of the properties of the properties of the properties of the pharmacy reports, resoffice, and admission Committee and Medical repharmacy reports, resoffice, and admission Committee and Medical Resource of the properties of the properti	Interim Administrator on M, and Regional Nurse 2021 at 3:40 PM revealed the QAPI Plan and and/or revision to the QAPI 209/16/2021 meeting. The landardized plan to ensure ed as needed at the QAPI cluded pressure ulcers, ral feeding tubes, and feeding tubes, are rehabilitation services, concerns of resident council, and family of or grievances, admissions, staff development, openings in, employee orientations, audit report, weight losses, tions, employees on family ence or leave of absence, cord compliance review, storative nursing, business actions. The QAPI cal Director approved the on 09/16/2021 to include the topics presented during with MDS Nurse #1 on M, MDS Nurse #2 on M, Regional Certified Dietary 21 at 2:26 PM and M, Former Activities ager #3 on 09/30/2021 at 8:34	{F 5	80}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		IPLE CONSTI	(X3) DATE SURVEY COMPLETED		
		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		200 NURS	DDRESS, CITY, STATE, ZIP CODE SING HOME LANE LE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 580}	12:45 PM and Centra 2:40 PM, revealed the at the QAPI meeting II 31). Interview with the Operations on 09/30/2021 at 3:20 Director on 09/30/202 meeting was conduct the duties of the Government	M, Housekeeping 2021 at 1:24 PM, (RT) #1 on 09/30/2021 at 1 Supply on 09/29/2021 at 2 information was presented held on 09/16/2021. 2 Vice President of 2021 at 4:10 PM, the Interim 0/2021 at 3:40 PM, DON #2 0 PM, and the Medical 21 at 3:25 PM revealed a 22 ed on 09/16/2021 regarding 23 erning Body including setting 25 to be implemented in the 26 eating information to other 27 erning Body. During the 28 persident of 29 persident of 20 pm, and the Medical 20 pm, and the Medical 21 at 3:25 PM revealed a 22 pm, and the Medical 23 persident in the 24 persident on 25 pm, and the Medical 26 pm, and the Medical 27 pm, and the Medical 28 pm, and the Medical 29 pm, and the Medical 20 pm, and the Medical 20 pm, and the Medical 20 pm, and the Medical 20 pm, and the Medical 20 pm, and the Medical 20 pm, and the Medical 20 pm, and the Medical 20 pm, and the Medical 20 pm, and the Medical 20 pm, and the Medical 20 pm, and the Medical 20 pm, and the Medical 20 pm, and the Medical 21 at 3:25 PM revealed a 21 at 3:25 PM revealed a 22 pm, and the Medical 23 pm, and the Medical 24 pm, and the Medical 25 pm, and the Medical 26 pm, and the Medical 27 pm, and the Medical 28 pm, and the Medical 29 pm, and the Medical 20 pm, and the Medical 20 pm, and the Medical 20 pm, and the Medical 20 pm, and the Medical 21 at 3:25 PM revealed a 22 pm, and the Medical 23 pm, and the Medical 24 pm, and the Medical 25 pm, and the Medical 26 pm, and the Medical 27 pm, and the Medical 28 pm, and the Medical 29 pm, and the Medical 20 pm, and the Medical 20 pm, and the Medical 20 pm, and the Medical 20 pm, and the Medical 21 at 4:10 pm, and the Medical 21 at 4:10 pm, and the Medical 26 pm, and the Medical 27 pm, and the Medical 28 pm, and the Medical 29 pm, and the Medical 20 pm, and the Medical 20 pm, and the Medical 20 pm, and the Medical 20 pm, and the Medical 21 at 4:10 pm, and the Medical 21 at 4:10 pm, and the Medical 21 at 4:10 pm, and the Medical 29 pm, and the Medical 20 pm, and the Medical 20 pm, and the Medical 20 pm, and the Medical 20 pm, a	{F 5	80}			
	Operations on 09/30/	2021 at 4:10 PM and the ultant on 09/30/2021 at 3:40					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED
		185256	B. WNG_		05	R 9/30/2021
	ROVIDER OR SUPPLIER **POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	(X5) COMPLETION DATE
{F 580}	Administrator with resmaterial for QAPI. Fur governing body would upcoming year. Interv Administrator on 09/3 he had been provided education regarding 0 34). Interview with the 09/30/2021 at 3:40 PN were conducted week ensure the quality of complied with the star compliance. Further in President of Operation PM, Regional Nurse 0 3:40 PM, MDS Nurse PM, MDS Nurse PM, MDS Nurse PM, MDS Nurse PM, Former Activities #3 on 09/30/2021 at 1:00 09/28/2021 at 2:26 PN PM, Former Activities #3 on 09/30/2021 at 1:00 09/29/2021 In admedical Director/Physis 3:25 PM revealed he QAPI meetings on 09 Further interview with 09/30/2021 at 3:40 PN	erning body provided the sources and education rither interviews revealed the dimeet quarterly for the view with the Interim 10/2021 at 3:40 PM revealed diwith resources and QAPI. Interim Administrator on M revealed QAPI meetings sty effective 09/16/2021 to care is monitored and indard of care and interview with the Vice ins on 09/30/2021 at 4:10 Consultant on 09/30/2021 at 1:39 in 09/30/2021 at 1:31 PM, etary Manager on M and 09/30/2021 at 1:52 Director/Dietary Manager I:30 PM, Medical Records AM, Human Resource	{F 5			
		API meeting attendance				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WING			i i	R
NAME OF P	ROVIDER OR SUPPLIER		1	,	STREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
					200 NURSING HOME LANE		
PARKVIE	N POST-ACUTE AND RE	HABILITATION CENTER			PIKEVILLE, KY 41501		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(75)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	(X5) COMPLETION DATE
(F 580)	80) Continued From page 75		{F 5	80	}		-
	sheet reflected the above interviews with no identified concerns.						
i		V #1 on 09/29/2021 at 11:55					
		t 12:58 PM, RN #4/Wound					
	on 09/30/2021 at 12:4	2021 at 2:54 PM, LPN #6					
		M and 09/30/2021 at 1:54					
		30/2021 at 12:50 PM, LPN					
		10:31 AM, SRNA #1 on					
	09/29/2021 at 3:40 PM		-				
		M SRNA #7 on 09/29/2021 9 on 09/29/2021 at 4:10 PM,					
		2021 at 3:04 PM, SRNA #22	1				
		PM and SRNA #23 on					
		M revealed they received					
		021. Interview with nursing				Ì	
		rbalized understanding of					
		btaining, documenting, and to the Registered Dietician					
		Regional DON on 09/30/2021					
	at 4:17 PM revealed s	staff was provided with					
		021 on proper weighing					
	techniques, obtaining,						
	reporting weight chan- Dietician.	ges to the Registered					
	Dietician.						
	36). Interview with For	rmer Activities Director and					
		ger on 09/30/2021 at 1:30	1				
	PM revealed she rece	eived education on					
		gional Certified Dietary					
		et order accuracy and					
		ssments to ensure diet					
		n staff enter diet orders into I record, the nurse entering			1		
		n communication to the					
		cludes diet and texture. She					
		the entered the order into					
	the tray card system to	o reflect the resident's diet					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
PARKVIE	V POST-ACUTE AND RE	HABILITATION CENTER		;	200 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID	SIIMMADV ST	ATEMENT OF DEFICIENCIES			T		T Avesto
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	COMPLETION DATE
(F 580)	1,120		(F 5	80)			
, coo,	orders. She stated that previous day would be meeting. Interview with 09/28/2021 at 2:26 Pt PM revealed she come Former Activities Dire addition, she stated the provide additional assist to her new role. 37). Interview with RN AM and 09/30/2021 at 2:409/29/2021 at 3:00 Pt PM, LPN #10 on 09/30/2021 at 09/29/2021 at 3:40 Pt 09/29/2021 at 3:29 PM, SRNA #1 SRNA #21 on 09/29/2020 on 09/29/2021 at 3:17 09/29/2021 at 4:10 Pt education on turning/r	at all diet orders from the ereviewed in the clinical that he Regional CDM on and 09/30/2021 at 1:52 spleted education with ctor/Dietary Manager #3. In that she had been on site to distance during the transition of the transitio	(F 5	180)			
	chair and from chair to turning, positioning, a	g residents from bed to bed. Observations of nd wound care with RN #11 11 AM for Resident #65					
	revealed no identified Therapy Manager on revealed she provided beginning on 08/19/20 turning/repositioning, transferring a resident	concerns. Interview with the 09/30/2021 at 1:18 PM I staff with education 021 regarding range of motion, and I from bed.					
	AM and 09/30/2021 a	I #1 on 09/29/2021 at 11:55 t 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 4 PM, LPN #7 on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING_				R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		001	0012021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	·	HOULD BE		(X5) COMPLETION DATE
{F 580}	PM, LPN #10 on 09/3 #11 on 09/30/2021 at 09/29/2021 at 3:40 PM 09/29/2021 at 3:29 PM, SRNA #1 SRNA #21 on 09/29/2021 at 3:17 09/29/2021 at 4:10 PM education on pressure turning and reposition nutrition, Positioning of and document a head and how to notify the RP of a new skin impair or email the Registers and the resident's repichanges. Interview with Consultant on 09/30/2 Regional DON on 09/30/2 Regional DON on 09/30/2 Regional DON on 09/30/2 Regional DON on 09/30/2 Regional DON on 09/30/2 Regional DON on 09/30/2 Regional DON on 09/30/2 Regional DON on 09/30/2 Regional DON on 09/30/2021 https://doi.org/10.2021/20.	M and 09/30/2021 at 1:54 30/2021 at 12:50 PM, LPN 10:31 AM, SRNA#1 on M, SRNA#11 on M SRNA#7 on 09/29/2021 9 on 09/29/2021 at 4:10 PM, 2021 at 3:04 PM, SRNA#22 7 PM and SRNA#23 on M revealed they received the ulcer prevention including sing, adequate hydration and devices, how to complete 1-to-toe skin assessment, registered dietician, MD and the dietician, the physician, resentative with any th Regional Nurse 2021 at 3:40 PM and the 30/2021 at 4:17 PM and staff on pressure ulcer turning/repositioning, and nutrition, Positioning lete and document a ssment, and how to notify n, physician and RP of a With any change to skin the will call or email the or new recommendations, presentative. OS Nurse #1 on 09/30/2021 se #2 on 09/30/2021 at 1:31 sistant #1 on 09/30/2021 at nager on 09/30/2021 at nager on 09/30/2021 at nager on 09/30/2021 at nager on 09/30/2021 at nager on 09/30/2021 at nager on 09/30/2021 at nager on 09/30/2021 at nager on 09/30/2021 at nager on 09/30/2021 at nager on 09/30/2021 at nager on 09/30/2021 at nager on 09/30/2021 at nager on 09/30/2021 at nager on 09/30/2021 at nager on 09/30/2021 at nager on 09/30/2021 at nager on 09/30/2021 at nager on 09/30/2021 at nager on 09/30/2021 at	{F 5	580}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL' A. BUILDI		ONSTRUCTION	((X3) DATE SURVEY COMPLETED	
		185256	B. WNG					₹
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		200	EET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE EVILLE, KY 41501		09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO BE		(X5) COMPLETION DATE
{F 580}	Central Supply on 0 #3 on 09/29/2021 at 09/30/2021 at 2:10 IDirector/Dietary Main 1:30 PM revealed the timely call light responding to 12:58 Nurse on 09/30/2021 at 12:44 at 3:00 PM and 09/30/2021 at 12:44 at 3:00 PM, SRNA #3 on 09/30/2021 at 10:31 at 3:40 PM, SRNA #3 on 09/29/2021 at 4:09/29/2021 at 3:04 ID at 3:17 PM and SRN PM, revealed they recall light response, president plan of care staff dress residents clothing and timely content of the content	09/29/2021 at 8:34 AM, 9/29/2021 at 2:40 PM, Cook 1:12 PM, Dietary Aide #3 on PM, Former Activities nager #3 on 09/30/2021 at ney received education on onse. In addition, interviews 9/2021 at 11:55 AM and PM, RN #4/Wound Care 1 at 2:54 PM, LPN #6 on PM, LPN #7 on 09/29/2021 10/2021 at 1:54 PM, LPN #10 1:50 PM, LPN #11 on AM, SRNA #1 on 09/29/2021 1411 on 09/29/2021 at 3:23 PM 12021 at 3:29 PM, SRNA #19 130 PM, SRNA #21 on PM, SRNA #22 on 09/29/2021 1A #23 on 09/29/2021 at 4:10 1A #23 on 09/29/2021 at 4:10 1A #23 on 09/29/2021 at 4:10 1A #23 on 09/29/2021 at 4:10 1A #23 on 09/29/2021 at 4:10 1A #23 on 09/29/2021 at 4:10 1A #23 on 09/29/2021 at 4:10 1A #23 on 09/29/2021 at 4:10 1A #23 on 09/29/2021 at 4:10 1A #23 on 09/29/2021 at 4:10 1A #23 on 09/29/2021 at 4:10 1A #23 on 09/29/2021 at 4:10 1A #23 on 09/29/2021 at 4:10 1A #23 on 09/29/2021 at 4:10 1A #23 on 09/29/2021 at 1:12 PM, 19/30/2021 at 2:10 PM, and 1A #23 on 09/29/2021 at 1:12 PM, 19/30/2021 at 2:10 PM, and 1A #24 PM #25 PM	{F 5	80}				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		;	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	03/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	(X5) COMPLETION DATE
{F 580}	entered into the electrobservation of RN #1 revealed the nurse was knowledge of the educoncerns. 41). Interview with RN AM and 09/30/2021 at 12:4 09/29/2021 at 3:00 PN PM, LPN #10 on 09/3 #11 on 09/30/2021 at 09/29/2021 at 3:40 PN 09/29/2021 at 3:23 PN at 3:29 PM, SRNA #15 SRNA #21 on 09/29/20 on 09/29/2021 at 4:10 PN education on identificaresidents with a changon identifying signs/sy hyperglycemia/hypogl protocol, documentation of identification on identi	g new care plans were conic medical record. on 09/29/2021 at 11:55 AM as able to demonstrate cation with no identified I #1 on 09/29/2021 at 11:55 t 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 t4 PM, LPN #7 on M and 09/30/2021 at 1:54 0/2021 at 12:50 PM, LPN 10:31 AM, SRNA#1 on M SRNA#11 on M SRNA#11 on M SRNA#7 on 09/29/2021 t on 09/29/2021 at 4:10 PM, 021 at 3:04 PM, SRNA#22 f PM and SRNA#23 on M revealed they received ation and assessment of the in respiratory status and mptoms of tycemia, facility diabetic ty resident change in tion of blood sugar in the tation of the physician and ders. In addition, interviews dieducation on tose levels. I #1 on 09/29/2021 at 11:55 t 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 4 PM, LPN #7 on M and 09/30/2021 at 1:54 0/2021 at 12:50 PM, LPN 10:31 AM, SRNA#1 on	{F 5	880)			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	41 3 Julius		ECONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
					100 NURSING HOME LANE		
PARKVIEV	W POST-ACUTE AND RE	HABILITATION CENTER			PIKEVILLE, KY 41501		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		_	· · · · · · · · · · · · · · · · · · ·		
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 580}	Continued From page 09/29/2021 at 3:29 PM, SRNA #1 SRNA #21 on 09/29/20 on 09/29/2021 at 3:17 09/29/2021 at 4:10 Pl education on complet with interventions and diagnosis of diabetes within forty-eight hour reviewing and providing resident/responsible page 44). Interview with MD at 1:39 PM, MDS Nur PM, Maintenance Ass 2:56 PM, Therapy Ma 1:18 PM, Housekeepi 09/30/2021 at 1:24 Pl Director (HR) on 09/3 Marketing Liaison on Medical Records on 00 Central Supply on 09/30 no 09/29/2021 at 1:54 Pl 12:58 PM, RN #4/Wo 09/30/2021 at 2:54 Pl 12:44 PM, LPN #7 on 09/30/2021 at 1:54 Pl at 12:50 PM, LPN #11 AM, SRNA #1 on 09/29/2021 at 09/29/2021 at 3:29 Pl 09/29/2021 at 4:10 Pl at 3:04 PM, SRNA #2 and SRNA #23 on 09/29/2021 at 3:04 PM, SRNA #2 and SRNA #23 on 09/29/2021 at 3:29 Pl 09/29/2021 at 3:04 PM, SRNA #2 and SRNA #23 on 09/29/2021 at 3:04 PM, SRNA #2 and SRNA #23 on 09/29/2031 at 3:04 PM, SRNA #2 and SRNA #23 on 09/29/2031 at 3:04 PM, SRNA #2 and SRNA #23 on 09/29/2031 at 3:29 Pl 09/29/2021 at 3:04 PM, SRNA #23 on 09/29/203	M SRNA #7 on 09/29/2021 9 on 09/29/2021 at 4:10 PM, 2021 at 3:04 PM, SRNA #22 7 PM and SRNA #23 on M, revealed they received ing a baseline Care Plan if goals relevant to the and a respiratory diagnosis is of admission, and ing a copy to the party. 20 S Nurse #1 on 09/30/2021 at 1:31 isistant #1 on 09/30/2021 at ing Supervisor on M, Human Resource 0/2021 at 10:48 AM, Senior 09/30/2021 at 10:55 AM, 29/29/2021 at 2:40 PM, RN #1 in 55 AM and 09/30/2021 at 10:55 AM, 29/29/2021 at 3:40 PM, RN #1 in 09/29/2021 at 3:40 PM, SRNA #1 in 09/29/2021 at 3:40 PM, SRNA 3:23 PM SRNA #7 on M, SRNA #19 Aide on M, SRNA #21 on 09/29/2021 at 3:17 PM in 29/2021 at 4:10 PM, Cook in 12 PM, Dietary Aide #3 on in 29/2021 at 4:10 PM, Cook in 12 PM, Dietary Aide #3 on in 20 in 2	(F 5			TE .	DATE
	1:30 PM revealed the	ager #3 on 09/30/2021 at y were educated on the					
	process of identifying	, preventing, and reporting					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		IDENTIFICATION NUMBER) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING_				R 30/2021	
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 200 NURSING HOME LANE PIKEVILLE, KY 41501	E	091	30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		COMPLETION DATE	
{F 580}	immediate intervention 45). Interview with RN AM and 09/30/2021 at 12:4 09/29/2021 at 3:00 PPM, LPN #10 on 09/30/20 they received educative techniques, obtaining reporting of weight chapter on 09/30/20 had received educative and provision of timelensure diet order according are put into the electrourse entering the orders from the previous formunication to the diet and texture. She orders from the previous friday, to ensure accordinical meeting, whice Friday, to ensure accordinication on facility put times and the use of fortified diets to ensure utilitional needs of reestablished national ground cultural, and ethnic needs of reestablished national ground cultural, and ethnic needs of reestablished national ground cultural, and ethnic needs of reestablished national ground cultural, and ethnic needs of reestablished national ground cultural and ethnic n	atifying and implementing and for wandering residents. If #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound (2021 at 2:54 PM, LPN #6 at PM, LPN #7 on M and 09/30/2021 at 1:54 at 10:31 AM revealed an on proper weighing and temperature with the Dietary (21 at 1:30 PM revealed she on on diet order accuracy by nutritional assessment to uracy. When the diet orders onic medical record, the der will send a written at dietary staff that will include further revealed all diet ous day are reviewed in the hoccurs Monday through uracy. The Dietary Manager on M revealed she received and in the hoccurs manager on M revealed she received and in the hoccurs manager on manager	{F 5	80}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING		1	(X3) DATE SURVEY COMPLETED	
		185256	B. WING				₹ 30/2021
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		1 031	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE		COMPLETION DATE
{F 580}	and/or portion sizes, scarts and snacks and 48). Interview with RN AM and 09/30/2021 at Care Nurse on 09/30/ on 09/30/2021 at 12:4 09/29/2021 at 3:00 PI PM, LPN #10 on 09/3 #11 on 09/30/2021 at Activities Director/Die 09/30/2021 at 1:30 PI education on the producation on 09/30/2021 at 1:39 PI 09/30/2021 at 1:39 PI 09/30/2021 at 1:18 PI Supervisor on 09/30/2 09/30/2021 at 12:58 F Nurse on 09/30/2021 09/30/2021 at 12:44 F at 3:00 PM and 09/30 on 09/30/2021 at 12:50 09/30/2021 at 10:31 A at 3:40 PM, SRNA#1	appropriate scoop sizes stocking snack/hydration hydrations. I #1 on 09/29/2021 at 11:55 tt 12:58 PM, RN #4/Wound 2021 at 2:54 PM, LPN #6 I4 PM, LPN #7 on If and 09/30/2021 at 1:54 0/2021 at 12:50 PM, LPN 10:31 AM and Former tary Manager #3 on If revealed they received less for entering, activating, the registered dietician's dietary orders. Interim Administrator on If If and	{F 5	i80}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		PLE CONSTRUCTION		(X3) DATÉ SURVEY COMPLETED	
		185256	B. WNG_		·		₹ 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
{F 580}	at 3:17 PM and SRN/PM, Cook #3 on 09/2 Aide #3 on 09/30/202 Activities Director/Die 09/30/2021 at 1:30 Pl received education or policy/guidelines, han Personal Protective E red zones. Observation and yellow zone on 0 revealed no identified were in the red or yel conducted on 09/28/2 09/30/2021 revealed the COVID-19 policy/ donning/doffing Perso (PPE), or the yellow/r 50). Interview with RN AM, and 09/30/2021 at 3 Care Nurse on 09/30/2 (LPN) #6 on 09/30/2021 at 3 1:54 PM, LPN #10 or LPN #11 on 09/30/20 they had received edi symptom monitoring admissions. A review #355 on 09/10/2021 at 3 COVID-19 symptom a resident orders. Resident orders. Resident #355 reveal COVID-19 symptom a resident #355 reveal COVID-19 symptom a resident orders. In ad #329, #328, #311, #6	M, SRNA #22 on 09/29/2021 A #23 on 09/29/2021 at 4:10 9/2021 at 1:12 PM, Dietary 1 at 2:10 PM, Former tary Manager #3 on M revealed they had in the COVID-19 Idwashing, donning/doffing Equipment (PPE), yellow and ion of the red facility zone 9/28/2021 at 2:12 PM I concerns. No residents Iow zones. Observations IO21, 09/29/2021, and Ino identified concerns with guidelines, handwashing, Inal Protective Equipment ed zones. I #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound I/2021 at 2:54 PM, LPN I/21 at 12:44 PM, LPN (LPN) I/2030/2021 at 12:50 PM, I/21 at 10:31 AM revealed I ucation entering COVID-19 Inders on all new I/2031 of newly admitted Resident I/2032 revealed the resident had I/2033 was discharged I/2034 revealed to the facility on I/2035 of re-admission for I/2037 review of Resident I/2037 review of Resid	{F 58	30)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG	(X3)	(X3) DATE SURVEY COMPLETED	
		185256	B. WING_			R	
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER	***	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		09/30/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X (EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{F 580}	AM, and 09/30/2021 Care Nurse on 09/30/2021 at 3 1:54 PM, LPN #10 or LPN #11 or 09/30/20 they had received ed of medication, right paticand right route. In adon the process to folk not available for admicalling the pharmacy obtaining the anticipa notifying the physicial would either be omitted ordered medication to included following neighysician, documentinew orders from the I record. 52). Interview with RN AM and 09/30/2021 at 3 1:54 PM, LPN #10 or LPN #11 on 09/30/20 they had received edemergency medication floor three (3) on 09/29/2021 at 3 medication administrations.	N #1 on 09/29/2021 at 11:55 at 12:58 PM, RN #4/Wound /2021 at 2:54 PM, LPN D21 at 12:44 PM, LPN (LPN) 3:00 PM and 09/30/2021 at 09/30/2021 at 12:50 PM, 21 at 10:31 AM revealed ucation on the five (5) rights stration including right ent, right dose, right time, ldition, they were educated by when a medication was inistration, which included to obtain the medication, they medication delivery time, if an ordered medication ed or given outside of the me. The education also	{F 5	80}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WING			R 09/30/2021	
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			9912321
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 580}	she was a new hire to received education remedication kit. 53). Interview with DC PM, MDS Nurse #1 or MDS Nurse #2 on 09. Maintenance Assistar PM, Therapy Manage Housekeeping Super PM, Human Resource 09/30/2021 at 10:48 / Liaison on 09/30/202 Records on 09/29/202 Supply on 09/29/202 Supply on 09/29/202 Supply on 09/29/202 PM, RN #4/Wound C 2:54 PM, LPN (LPN) PM, LPN (LPN) PM, LPN (LPN) #7 or 09/30/2021 at 1:54 PM at 12:50 PM, LPN #1 AM, SRNA #1 on 09/2 #11 on 09/29/2021 at 09/29/2021 at 3:29 PM at 4:10 PM, SRNA #2 SRNA #22 on 09/29/2 Were educated on the contact information at Coordinator. Observa 09/28/2021, 09/29/202 revealed signage pos Administrator's contact Abuse Coordinator pot 54). Review of audits weekly head-to-toe signage for the contact information at Coordinator pot 54). Review of audits weekly head-to-toe signage for the contact information at Coordinator pot 54). Review of audits weekly head-to-toe signage for the contact information at Coordinator pot 54). Review of audits weekly head-to-toe signage for the contact information at Coordinator pot 54). Review of audits weekly head-to-toe signage for the contact information at Coordinator pot 54). Review of audits weekly head-to-toe signage for the contact information at Coordinator pot 54). Review of audits weekly head-to-toe signage for the contact information at Coordinator pot 54). Review of audits weekly head-to-toe signage for the contact information at Coordinator pot 54).	30/2021 at 2:27 PM revealed the facility and had garding the emergency on the facility and had garding the emergency on 9/30/2021 at 3:20 m 09/30/2021 at 1:39 PM, 1/30/2021 at 1:31 PM, 1/30/2021 at 1:31 PM, 1/30/2021 at 1:31 PM, 1/30/30/2021 at 1:18 PM, 1/30/30/30/2021 at 1:24 to 1/30/30/30/2021 at 1:24 to 1/30/30/30/30/30/30/30/30/30/30/30/30/30/	{F 5	80}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		185256	B. WING			F	R 30/2021		
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 200 NURSING HOME LANE PIKEVILLE, KY 41501	ΣE		30/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE APPROPRIAT		(X5) COMPLETION DATE		
{F 580}	at 10:20 AM revealed review of the medical #324, #45, #14, #357 revealed the weekly vicompleted with physic notifications. Interview 09/30/2021 at 3:53 Pl of new and/or worsen reviewed the resident with Medical Director revealed that he was worsening skin impair interventions to preverevealed that he partiand discussed ongoin residents. Interview won 09/30/2021 at 5:05 team discussed all auricluding new and/or and interventions imposticularly supplies revealed that the audifor four (4) weeks and months. A review of a Observation of floor the (5) supplies and revier identified concerns. 56). Interview with the 09/30/2021 at 4:17 Pl 09/30/2021 at 3:20 Pl were audited during mensure all new areas been care planned with the concerns.	no identified concerns. A record for Resident #65, , #27, #74, and #358 vound assessments cian and responsible party v with the Dietician on M revealed she was notified ing pressure ulcers and s as indicated. Interview on 09/30/2021 at 3:25 PM notified of new and/or ments and new ent decline. He further cipated in QAPI meetings ag audits and care of with the Interim Administrator of PM revealed the QAPI addits in QAPI meetings, worsening pressure injuries lemented. entral Supply on 09/29/2021 she completed the audits of s on 08/28/2021. She further its were conducted weekly of then monthly for three (3) audits revealed no concerns. Incree (3), four (4), and five ew of the audits revealed no	{F 5	580}					

■ 2 · 2		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			I	R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		200	REET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE SEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
{F 580}	on 09/30/2021 at 10:5 completed visual rour hygiene, toileting, increpositioning in additi Review of audits revenals, clothes, body or dry, toileted as requehair clean and combe clean, call light within applicable and turned 58). Interview with the Operations on 09/30/. Senior Marketing Liai AM revealed they parmonitoring, and monitimes including the leunanswered. Interview activated more than faddressed with the strevealed they were cand different shifts. 59). Interview with the 4:17 PM revealed shore respiratory assessme communication Mond clinical meeting. She assessed to ensure the respiratory status and completed had physicimplementation of phy Resident #315 SBAR #324 SBAR completed completed on 08/15/2	e Senior Marketing Liaison 55 AM revealed he inding of residents assessing continence, and resident con to other leadership staff, caled staff were auditing dor, incontinent clean and sted or every two (2) hours, id, sheets and blankets reach, facial hair shaved if and repositioned. e Vice President of 2021 at 4:10 PM and the son on 09/30/2021 at 10:55 ticipated in visual toring call light response ingth of time call lights go ws revealed any call five (5) minutes were aff. A review of audits completed on different units	{F 5	80}			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ') MULTIPLE CONSTRUCTION SUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				₹ 30/2021	
	ROVIDER OR SUPPLIER POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	031	00/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
{F 580}	revealed no identified 60). Review of Reside admitted on 09/10/20; had a baseline care p 09/10/2021. Resident 09/25/2021 and re-ad 09/28/2021. Further re for Resident #355 rev comprehensive care p (11) days after admissi re-admission for Resi resident had a baselir 09/28/2021. Interview 09/30/2021 at 1:39 Pl 09/30/2021 at 1:31 Pl	cated. A review of audits concerns. ent #355, who the facility 21, revealed the resident lan developed on #355 was discharged on mitted to the facility on eview of the medical record realed staff completed the plan on 09/21/2021 (eleven sion). A review of dent #355 revealed the ne care plan developed on with MDS Nurse #1 on M and MDS Nurse #2 on M revealed all new missions to the facility were to the morning clinical	{F 5	80)				
	days from 07/16/2021 concerns with baselin MDS Nurse #1 on 09/16 revealed new/admissibeing updated as need 62). Interview with MI at 1:39 PM revealed in plans were being audicompletion, accuracy was conducted with the responsible party with admission/re-admission/r	ion baseline care plans were ided in morning meetings. OS Nurse #1 on 09/30/2021 new admission baseline care ited Monday-Friday for and to ensure a review ne resident and/or in 48 hours of						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WNG_			R 09/30/2021	
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501		03/30/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			((EACH CORRECTIVE ACTION S	OVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{F 580}	delivered to resident and education as nearevealed no identified dates as indicated. 63). Review of the au and/or CDM revealed stated with no identified the Regional Certified 09/28/2021 at 2:26 PPM, and Dietary Man 1:30 PM revealed training the Regional Certified 09/28/2021 at 2:26 PPM, and Dietary Man 1:30 PM revealed training on 8/15/20 education. Further rerevealed five (5) staff four (4) weeks from 0 on 09/13/2021 with no review of the verbal of quizzed on respirator hypo/hyperglycemia, notification. Interview Consultant on 09/30/2021 at 0 on 09/30/2021 at 1:3 performed verbal quizassessment of reside respiratory status, ide hyperglycemia/hypog protocol, documenting condition, notification following physician of	lan completion, care plan and/or responsible party, aded. A review of the audits of concern with completion dits completed by the DM at they were completed as ed concerns. Interview with a Dietary Manager on M and 09/30/2021 at 1:52 ager #3 on 09/30/2021 at 1:52 ager #3 on 09/30/2021 at 1:52 ager #3 on 09/30/2021 at 1:52 ager #3 on 09/30/2021 at 1:52 ager #3 on 09/30/2021 at 1:52 ager #3 on 09/30/2021 at 1:52 ager #3 on 09/30/2021 at 1:52 ager #3 on 09/30/2021 at 1:52 ager #3 on 09/30/2021 at 1:52 ager #3 on 09/30/2021 at 00/2022 at	{F 5	80}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (DENTIFICATION NUMBER: A. BUILDING				(X3) DATE SURVEY COMPLETED			
		185256	B. WNG		!	R 09/30/2021	
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZI 200 NURSING HOME LANE PIKEVILLE, KY 41501	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	· 1000000000000000000000000000000000000	CTION SHOULD BE		(X5) COMPLETION DATE
{F 580}	65). Interview with the 09/30/2021 at 4:17 Pl audits of documented Monday through Frida She further revealed to less than 60 and/or grataff were expected to Responsible Party, ar follow physician order stated she identified to 08/12/2021 to have a and one (1) on 09/20/glucose level of 465 vevidence the licensed process. She provide and LPN #5. A Review further concerns. A R RN #2 and LPN #5 rethe facility process. 66). Review of verbal was verbally asked si when to report, signs and wandering interveverbal quizzes reveal quizzed daily for one 08/19/2021 with no id review revealed verbathree (3) times a wee 08/21/2021 to 09/02/2 concerns. A review of that verbal quizzes we per week for four (4) verbal quizzes we per week for four (4) verbal quizzes we per week for four (4) verbal quizzes we per week for four (4) verbal quizzes we per week for four (4) verbal quizzes we per week for four (4) verbal quizzes we per week for four (4) verbal quizzes we per week for four (4) verbal quizzes we per week for four (4) verbal quizzes we per week for four (4) verbal quizzes we per week for four (4) verbal quizzes we per verbal quizzes v	und Care Nurse on M, LPN (LPN) #6 on PM, revealed they quizzes with facility staff. Regional DON on M revealed she completed blood glucose levels ay in the clinical meeting. that with any blood sugar reater than 40, the facility o notify the physician, nd Registered Dietician and rs. The Regional DON one (1) resident on blood glucose level of 430 '2021 to have a blood	{F 5	580}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WNG_		ne ne	R 9/30/2021	
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE	
{F 580}	Consultant on 09/30// 09/30/2021 at 4:17 Pl 09/30/2021 at 1:39 Pl the completion of veri interview revealed the verbally quizzed on the tool (signs and sympton report, signs and sympton reducation was completed used to complete the resident repor	with the Regional Nurse 2021 at 3:40 PM, RDON on M, and MDS Nurse #1 on M revealed each assisted in bal staff quizzes. Further at each staff member was the each staff member was the areas listed on the audit owns of abuse, when to optoms of wandering and rns), and any need for eted immediately with each SRNA #11 on 09/29/2021 at #6 on 09/30/2021 at 12:44 on 09/29/2021 at 3:00 PM and M, RN #1 on 09/29/2021 at 2:54 PM, RN eteron 09/30/2021 at 2:54 PM, 29/29/2021 at 2:40 PM, 29/29/2021 at 1:18 PM, 29/29/2021 at 1:18 PM, 29/2021 at 2:56 PM revealed extra process of the proc	{F 58	30}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		1 IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		185256	B. WING			R 9/30/2021	
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	The second secon	HOULD BE	(X5) COMPLETION DATE	
{F 580}	Regional Nurse Cons PM and DON #2 on Orevealed all-new admin the morning clinical appropriate assessment on Og/30 PS 3 AM and on Og/30 Resident # 27 revealed of unknown origin.	alle wandering risk are completion. Interview with sultant on 09/30/2021 at 3:40 19/30/2021 at 3:20 PM alissions would be reviewed all meeting to ensure eents, including the sment, had been completed. Arealed that residents ar wandering would be meeting and appropriate eented. Herewis performed for residents are or greater revealed no continued review revealed and on 08/13/2021 with ten are completed for four (4) assidents for eight (8) weeks. And 09/30/2021 at 2:23 PM, and 09/30/2021 at 1:39 PM assisting in completing audits are concerns identified. Review 18/13/2021 for review of assessments for residents aless than eight (8) to ensure and of unknown origin revealed as Interview with Regional 19/30/2021 at 3:40 PM, and 21 at 3:20 PM revealed they alterials as indicated with no	{F 5	80)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		185256	B. WNG_				R 30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		ILD BE		(X5) COMPLETION DATE
{F 580}	electronic medical recin the diet/tray card serview of Resident # 09/29/2021 at 12:04 for 09/29/2021 at 12:04 for 09/29/2021 at 12:04 for 09/29/2021 at 12:04 for on 09/29/20 diets were served as review of audits reveal weekly for four (4) weekly for four (4) weekly for four (4) weekly for two (2) weekly for two (2) weekly for two (2) weekly for two (2) weekly for two (2) weekly for two (2) weekly for two (2) weekly for one (1) former Activities Directly for one (1) former Activities Directly for one (2) 09/30/2021 at 1:30 Ply Manager on 09/28/2021 at 1:52 Ply performed as indicated revealed that meals wincluding breakfast at PM, and dinner at 5:00 09/28/2021 at 5:03 Ply had been served on ton 09/29/2021 lunch at the third floor at 12:16 Fifth floor at 12:34 PM 71). Review of Reside 09/29/2021 at 12:04 for 09/29	of resident diet orders from cords against orders entered oftware to ensure accuracy. 308's tray card on PM, Resident #39's tray card 106 PM, and Resident #334 21 at 12:30 PM revealed ordered by the physician. A aled audits were conducted teks. eted audits revealed random wice daily for one (1) week . Starting 08/30/2021, bbserved two (2) times per as and then weekly from) month. Interview with ctor/Dietary Manager #3 on M, Regional Certified Dietary 21 at 2:26 PM, and M revealed audits were ed. Further interviews were served as scheduled, 7:00 AM, lunch at 12:00 to PM. Observation on M revealed the evening meal the third floor. Observation meal revealed meals arrived proximately 12:16 PM, the PM and 12:24 PM, and the	{F 5	680}			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF D	DOUBLE OF STREET	103236	B. WIING.			09/	30/2021	
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
{F 580}	beverage preferences admission and enterin system. A review of a were audited daily for 09/15/2021 to 09/21/2 audits revealed snack beginning on 09/22/2 Regional Certified Die 09/28/2021 at 2:26 Pl PM revealed she aud not identified any con 72). Interview with the (HR) on 09/30/2021 at completed audits for time clock punches. Sconcerns. Observatio 09/28/2021, 09/29/20 revealed no concerns 73). Interview with the on 09/30/2021 at 3:40 at 4:17 PM, DON #2 and Interim Infection 09/30/2021 at 3:10 Pl being conducted with handwashing, isolatic donning/doffing PPE, variance or identified immediately. A review were conducted begin shifts and units.	for obtaining food and swithin seventy-two hours of ing the preferences into the udits revealed snack intakes one (1) week from 2021. Further review of the its were audited weekly 021. Interview with the etary Manager on M and 09/30/2021 at 1:52 ited snack intake and had cerns. The Human Resource Director at 10:48 AM revealed she daily staff screening against of entry doors on 21, and 09/30/2021 at 3:20 PM, RDON on 09/30/2021 at 3:20 PM, Control Nurse on M revealed audits were observations of on signage and zones, mask compliance. Any concerns will be addressed of the audits revealed they noting 09/17/2021 on random at Regional Nurse Consultant to PM revealed she was not other members to	{F 5	80}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION ANALOGO.		FIPLE CONSTRUCTION NG	((X3) DATE SURVEY COMPLETED	
		185256	B. WNG_			R 09/30/2021	
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	,		00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	E	(X5) COMPLETION DATE
{F 580}	no identified concerns 11:55 AM and 09/30/20 (LPN) #6 on 09/30/20 #7 on 09/29/2021 at 3 1:54 PM, LPN #10 on LPN #11 on 09/30/20 concerns with obtaining and/or receiving medication pass or the third floor and 09/revealed no identified medications. In additionarcotic count on the 12:50 PM revealed no 12:50 PM revealed no 13:40 responsible for complipass observations be stated she had not idensidents not having a counts. A review of autilized the Centers for Element Pathway for conduct the medication revealed a minimum of were observed daily from 15 identified concerns. For observations revealed administration was obtained in 15:00 AM.	A review of audits revealed 3. RN #1 on 09/29/2021 at 2021 at 12:58 PM, LPN 21 at 12:44 PM, LPN (LPN) 3:00 PM and 09/30/2021 at 09/30/2021 at 10:31 AM revealed no ng scripts for medications cations timely. Observation of 09/29/2021 at 4:35 PM on 30/2021 at 8:09 AM concerns with missing on, observation of the fifth floor on 09/30/2021 at 0 identified concerns. Regional Nurse Consultant Demonstration of the particular of th	(F 5	80}			
		M revealed medication peing reviewed in clinical					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE IDENTIFICATION NUMBER: A. BUILDING			ONSTRUCTION		SURVEY
-		185256	B. WING			1	R /30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		200	REET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE (EVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
(F 580)	meetings Monday through Friday against ordered		(F 5	80}			
(F 584) SS=E	•		(F 5	84}			12/30/21
	but not limited to recesupports for daily living. The facility must provided \$483.10(i)(1) A safe, to homelike environment use his or her personations. (i) This includes ensureceive care and servided physical layout of the independence and do (ii) The facility shall extra protection of the more theft. §483.10(i)(2) Houseks services necessary to and comfortable interior \$483.10(i)(3) Clean being good condition; §483.10(i)(4) Private of resident room, as specific as specific and comfortable interiors.	and to a safe, clean, elike environment, including iving treatment and ig safely. ide- clean, comfortable, and it, allowing the resident to all belongings to the extent ring that the resident can ices safely and that the facility maximizes resident it is not pose a safety risk. Exercise reasonable care for esident's property from loss eeping and maintenance in maintain a sanitary, orderly, for;					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				₹
NAME OF PI	ROVIDER OR SUPPLIER	103200	2, 11,110		TREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
PARKVIE	N POST-ACUTE AND RE	HABILITATION CENTER	,	2	00 NURSING HOME LANE IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	(X5) COMPLETION DATE
{F 584}	§483.10(i)(6) Comford levels. Facilities initial 1990 must maintain a 81°F; and	e 97 rable and safe temperature rable and safe temperature rally certified after October 1, remperature range of 71 to raintenance of comfortable	{ F 5	84}			
	by: Based on observation the facility's policy, it is failed to provide a cle homelike environment (57) sampled resident #321, Resident #36, It and Resident #36, It and Resident #316 and Resident #316 and Resident #316 and Resident #316 and Resident #316 and Resident #316 and Resident #36, Resident #86, Resid	t for nine (9) of fifty-seven ts (Resident #3, Resident Resident #96, Resident Resident #39, Resident #92 The facility failed to ensure esident #86 had a clean and Resident #39 had clean s #39's and #3's floor was ty failed to ensure Resident esident #316 and Resident ctioning shower/bath showerhead in the unit else in the sident for interest in the sident for interest in the sident for interest in the unit else in the sident for interest in the si			F 584 Safe/Clean/Comfortable/Homelike Environment Criteria 1: a) The bathroom for resident #316 and #86 was deep cleaned and sanitized to address any lingering odor b) Resident #39 is provided clean linens. c) Staff remove soiled linen from the room for Resident #39 and #3 d) The showerhead in the unit shower room for Residents #96, #86, #316 and #15 was repaired and is in proper working order. Criteria 2: a) On 11/1/2021 the Direct of Maintenance, and/or Director of Housekeeping and/or Administrator identified an repairs or cleaning issues be addressed in resident care and common areas, all identified issues we prioritized and/or put on a schedule. Criteria 3: a) Maintenance staff have received in-service education on 11/1/2	s. t or to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED
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		185256	B. WING_	_		09/	30/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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LVIVIAIE	F FOST-ACUTE AND RE	HABILITATION CENTER	P		IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 584)	Continued From page	98	(F 5	84}			
	the extent possible. Find management sharpossible, the charactereflected a personalize characteristics include orderly environment, lighting, inviting colors furniture and room are bath linens that were neutral scents, plants appropriate, comforta (71- 81 degrees Fahrnoise levels. Further estaff and management extent possible, the control that reflected a depensetting. These characteristics and medication carts, and	ble and safe temperatures enheit), and comfortable review revealed the facility's at shall minimize, to the haracteristics of the facility sonalized, institutional eteristics included: overhead dors, institutional signage, chair and bed. 27/2021 at 10:45 AM biled laundry and linens on			by the Director of Maintenance/Administrator/Designee of maintaining a safe/clean/comfortable/homelike environment which included but was not limited to: completing monthly maintenance audits to maintain equipment function and identify the need for any repairs; and the need to check and address all maintenance requests timely. b) Housekeeping staff has received in-service education on 11/1/2 by the Director of Housekeeping/Administrator/Designee maintaining a safe/clean/comfortable/homelike environment which included but was no limited to: completing monthly housekeeping audits to identify any cleaning issues; and the need to identify and address cleaning issues during dai assignments.	ot ed for /e 21 on	
	Further observation of bedside tables were startoughout the rooms linens were observed #39's room. Odors of in residents' rooms will floor in Resident #332 Observations and inte on 07/27/2021 at 11:0 setting on the side of resident's urinal was a	erview with Resident #332 00 AM revealed he/she was			Criteria 4: a) The Administrator will review/sign off on the weekly TELS wo order completion audits completed by t Maintenance and Housekeeping departments beginning first week of November 2021 b) The Administrator/designer will complete random audits of the facil auditing one unit on different days of the week so that each patient care unit is audited weekly to identify any maintenance or housekeeping issues weekly x 4 weeks then monthly x 2	he e ity ,	
		he urinal. A strong odor of e resident's room, and on			months beginning week of November 2 2021. Audits will be reviewed in QAPI	.2,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUI IDENTIFICATION NUMBER: A. BUILE			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		185256	B, WNG_			R 09/30/2021		
NAME OF PI	ROVIDER OR SUPPLIER	- V		STREET ADDRESS, CITY, STATE, ZIP CODE				
DARKVIEN	W DOOT 40UTE 4410 OF	HADILITATION OF UTCO		20	00 NURSING HOME LANE			
PARKVIEV	V POST-ACUTE AND RE	HABILITATION CENTER		Р	IKEVILLE, KY 41501			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)			COMPLETION DATE	
{F 584}	Continued From page	99 Resident #332 stated, "I	{F 5	84}	monthly x3 months then quarterly until	in		
	am always spilling pe I can't get anyone to	e all over the place because empty this for me." referring her observations revealed			substantial compliance.	ın		
	the floor in the resider substance and the St Surveyor's shoes stud observations were co	nts room had a sticky ate Survey Agency's ck to the floor while nducted. Three (3) pieces nen were also observed on			Criteria 5: Date of compliance: 12/30/2021			
	11:02 AM revealed a brown discoloration a pillow cases. Interview revealed that he/she	ent #17 on 08/05/2021 at fitted sheet with a large nd two (2) pillows without w with Resident #17 would like to have clean es on his/her two (2) pillows		!				
	Cancer. Review of his assessment dated 06	dmitted him/her on etes, Hypertension and						
	10:50 AM, revealed h changed unless he/sl changed. Resident # washcloths and linen:	nt #39, on 07/27/2021 at is/her sheets were not he requested them to be 39 stated that soiled s were placed on the floor of yed until housekeeping						
	11:00 AM revealed th	nt #3 on 07/27/2021 at e facility piled his/her soiled ntil housekeeping picked it			ii e			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100000000000000000000000000000000000000	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
	185256	B, WNG		R 09/30/2021		
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE	(XS) COMPLETION DATE	
at 2:19 PM, revealed R blankets and washcloth were stained when pro blankets were soiled w stuck to the resident. If the facility had no clear available to provide to Interview with State Re (SRNA) #4, on 07/28/2 resident rooms were di residents' rooms were stated some of the curf feces on them and hou the curtains or mopped rooms. She further stat rooms for cleanliness, now. SRNA #4 stated "nasty", and it had new Interview with the Hous 07/27/2021 at 4:08 PM present on blankets, lir facility would re-wash t stated all clean linens w by housekeeping staff remained present after However, the Houseke linens were not checke resident floor. Per the resident rooms were cl cleanliness. She state pick up soiled linen, lat resident rooms timely t	Member #1, on 07/28/2021 Resident #321 had dirty hs. She stated the blankets wided, and when the with pus and blood they Further interview revealed in blankets or washcloths him/her. Registered Nurse Aide R021 at 7:35 PM, revealed irty and the floors in the not cleaned regularly. She tains in the rooms had usekeeping never changed do the floors in the resident ted they used to check the but no one seemed to care the residents' rooms were ter been like that before. Sekeeping Supervisor, on I, revealed if stains were thens, or washcloths, the those items. She further were visually checked daily and disposed if stains replied before the Housekeeping Supervisor, hecked weekly for do staff was expected to undry, and trash from to ensure a clean ints. She stated this was	{F 5	84}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		185256 B. WING		R 09/30/2021				
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X1) COMPLETION DATE	
{F 584}	2. Observation on 0.7 revealed Resident #3 shared a restroom ar and urine. Significant both resident rooms. Interview with Reside 11:45 AM, revealed his been full of feces and and smelled bad. Re could not use the restroom to use the restroom to use the restroom to use the restroom to use the restroom and full of feces and full of feces and full of feces and full of feces and full of feces and urine. Reside 12:15 PM revealed Resident #316's was not fixed and it with the Ma 07/27/2021 at 4:00 Pissues were reported in the maintenance be resident floor. He statwo (2) to three (3) tit attention was needed repairs immediately.	/27/2021 at 11:45 AM into and Resident #86's ind the toilet was full of feces it odor was noted throughout ent #316, on 07/27/2021 at inis/her restroom toilet had if urine for a couple of days sident #316 stated he/she troom and he/she was he hall to another resident's froom. He/she further stated would fix it, but they had not. ent #86, on 07/27/2021 at inis/her toilet had been out of is and urine for about two (2) stated it was a shared and no one had come to fix it ent #15, on 07/27/2021 at tesident #316 and Resident use his/her restroom im was out of order and full esident #15 stated it was and Resident #86's toilet was not their fault. intenance Supervisor, on M, revealed maintenance by staff placing repair slips oxes located on each alted the boxes were checked mes daily, and if immediate d, maintenance would make	{F 5	84}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R 30/2021
	ROVIDER OR SUPPLIER **POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501		00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 584}	that Resident #86 and toilet was clogged and 3. Observation of 5th 07/27/2021 at 12:20 head had been install in the tub in the show Interview with Reside 12:10 PM, revealed the unit/floor was not wor for about a week. Interview with SRNA: PM, revealed the sho had been broken. She maintenance when recould fill out a slip and call maintenance. Interview with the Mai 07/27/2021 at 4:00 Pl aware the shower head broken until two (2) direplaced it just that m Supervisor, maintena staff placing repair slip boxes located on each boxes were checked daily, and if immediate maintenance would recommend the floor of laundry on the floor of laundry on the floor of laundry on the floor of laundry on the floor of laundry on the floor of laundry on the floor of laundry on the floor of laundry on the floor of laundry on the floor of safe state were expected minimized. She state	d Resident #316's shared d full of feces/urine. floor shower room on PM revealed a new shower led with the old showerhead ver room. ent #96, on 07/27/2021 at the shower head on the rking and had been broken #7, on 07/27/2021 at 12:15 ower head on the fifth floor e stated staff reported to epairs were needed. They d put in maintenance box or intenance Supervisor, on M, revealed he was not ad on the 5th floor was rays ago. He stated he had norning. Per the Maintenance ch floor. He further stated the two (2) to three (3) times the attention was needed, epair them immediately. strator, on 08/10/2021 at the expected resident rooms of trash and no soiled linen or. She further stated resident d to be mopped and odors	{F 5	i84}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING_			R 30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE
(F 584)	and notify maintenand and those repairs were timely. The Administr soiled linens, or non-vequipment were not at 4. Review of Resident revealed the facility re 04/15/2021 with Diaborous Disease and Cellulitis Quarterly MDS assess revealed the resident cognition with a BIMS Observation of Reside 08/05/2021 at 11:00 A toilet seat with stool sollet seat with Reside stool has been there in not clean it when {he/	staff was expected to call ce of any immediate repairs re expected to be done rator stated unclean rooms, working toilets and shower acceptable. It #92's medical record e-admitted him/her on setes, Chronic Kidney a. Review of his/her sment dated 06/30/2021 had moderately impaired it score of 09. Lent #92's toilet on AM revealed an elevated meared on the back rim. Int #92 revealed that the for hours and the "staff will	{F 5	84}		
{F 585} SS=D	on 08/05/2021 at 11:5 smeared on the back stated that the facility bothers" him/her. Grievances CFR(s): 483.10(j)(1)-(§483.10(j)(1) The resignievances to the facility that hears grievances reprisal and without ferminated that hears grievances reprisal and without ferminated that hears grievances reprisal and without ferminated that hears grievances reprisal and without ferminated that hears grievances reprisal and without ferminated that hears grievances reprisal and without ferminated that hears grievances reprisal states are supplied to the property of the property		(F 5	85}		11/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				₹ 30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	03/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 585)	respect to care and trefurnished as well as the furnished, the behavior residents, and other of facility stay. §483.10(j)(2) The residentility must make proceeding grievances the accordance with this paracordance with this paracordance with this paracordance with this paracordance policy to end all grievances regal contained in this paraprovider must give a containe	eatment which has been not which has not been or of staff and of other concerns regarding their LTC death has the right to and the ampt efforts by the facility to be resident may have, in coaragraph. It was make information ance or complaint available assure the prompt resolution right to residents' rights graph. Upon request, the copy of the grievance policy rievance policy must andividually or through locations throughout the ide grievances or ally in writing; the right to file usly; the contact information all with whom a grievance is or her name, business email) and business phone are expected time frame for the grievance; the right cision regarding his or her natct information of with whom grievances may	{F 5	85}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	10_			3
		185256	B. WING_				30/2021
NAME OF P	ROVIDER OR SUPPLIER			ş	TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	V POST-ACUTE AND RE	HABILITATION CENTER	ľ		000 NURSING HOME LANE		
				P	PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 585}	(ii) Identifying a Grieveresponsible for overse receiving and tracking conclusions; leading a by the facility; maintai information associated example, the identity of grievances submitted written grievance decicoordinating with state necessary in light of s (iii) As necessary, tak prevent further potent right while the alleged investigated; (iv) Consistent with §4 reporting all alleged viabuse, including injuriand/or misappropriation and/or misappropriation and/or misappropriation as required by State I; (v) Ensuring that all winclude the date the grievalum of the pertinasto whether the grieconfirmed, any correctaken by the facility as and the date the writter of the residents of the residents' rights or if an outside entity of the pertinastor of the residents' rights or if an outside entity in the state of the residents' rights or if an outside entity in the state of the residents' rights or if an outside entity in the state of the residents' rights or if an outside entity in the state of the residents' rights or if an outside entity in the state of the residents' rights or if an outside entity in the state of the residents' rights or if an outside entity in the state of the residents' rights or if an outside entity in the state of the residents' rights or if an outside entity in the state of the residents' rights or if an outside entity in the state of the residents' rights or if an outside entity in the state of the residents' rights or if an outside entity in the state of the residents' rights or if an outside entity in the state of the residents' rights or if an outside entity in the state of the residents' rights or if an outside entity in the state of the residents' rights or if an outside entity in the state of the resident in the state of the resident in the state of the resident in the state of the resident in the state of the resident in the state of the resident in the state of the resident in the state of the resident in the state of the resident in the state of the resident in the state of the res	and advocacy system; ance Official who is being the grievance process, a grievances through to their any necessary investigations ining the confidentiality of all divith grievances, for of the resident for those anonymously, issuing issions to the resident; and e and federal agencies as specific allegations; ing immediate action to ial violations of any resident diviolation is being as a specific allegations; in the resident property, by vices on behalf of the provider; and aw; written grievance decisions rievance was received, a first resident's grievance, a sestigate the grievance, a sestigate the grievance, a statement avance was confirmed or not estive action taken or to be a result of the grievance, and decision was issued;	⟨F 5	85}			

			_			OMP NC	<u>). 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
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		185256	B. WING	_		09/	30/2021
NAME OF P.	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER		20	00 NURSING HOME LANE		
				P	IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 585}	Organization, or local confirms a violation for rights within its area of (vii) Maintaining evide	law enforcement agency or any of these residents' of responsibility; and ence demonstrating the or s for a period of no less than	{F 5	85}			
	by: Based on interview, in of the facility failed to redietary/food complain (57) sampled resident (57) sampled resident (57) sampled resident (57) sampled resident (57) sampled resident (57) sampled resident (57) sampled resident (57) sampled resident (57) sampled resident (57) sampled resident (57) sampled resident (57) sampled resident (57) sampled resident (57) sampled (57) s	ained to the facility about n 04/26/2021; however, nted evidence the facility e procedure to investigate, at the grievance for Resident as grievance policy titled nts, Recording and evision date of April 2017, e/complaint form would be vance and complaints and a d investigate the The Grievance Officer to the administrator and in to the form and the grievance eallable to the person acting			F 585 Grievances Criteria 1: Resident #156 discharged from facility on 5/11/21 Criteria 2: a) A resident council meet was held on 10/7/21, with residents in attendance asked if they had any concerns/grievances that they had reported that had not been resolved to their satisfaction. There were no unresolved issues reported. b) Residents with a BIMS score of 8 or higher that did not attend resident council meeting conducted on 10/7/21 were interviewed by the Direct of Social Services/Designee to determit if they had any concerns/grievances that they had reported that had not been resolved to their satisfaction. There were no unresolved issues reported. Criteria 3: Inservice education was provided by the Director of Social Services/Administrator or Designee for	the or ne at re	
	Review of the closed	medical record for Resident			staff on the facility policy and procedure for the reporting of concerns/grievance: which included but was not limited to: t	3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R
NAME OF D	ROVIDER OR SUPPLIER	100200	D. 111110			09	/30/2021
MAINE OF FI	NOVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	W POST-ACUTE AND RE	HABILITATION CENTER			200 NURSING HOME LANE		
	<u> </u>			F	PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 585}	Continued From page	107	{F 5	85}			
	03/05/2021 with diagr Diabetes Mellitus Typ To Excess Calories.	e II and Morbid Obesity Due	•	,	form to use for documenting concerns/grievances and where to loca these; who they are to provide the completed concern/grievance form; the need to complete follow up documental	tion	
	Data Set (MDS) Asse revealed the resident Brief Interview for Mei fifteen (15) out of fifter resident was cognitive				on all reported concerns/grievances as assigned. Criteria 4: Beginning with December monthly resident council the minutes with the reviewed for any concerns/grievance by the Activities director or designee and	ill es	
	A review of Resident #156's Nutrition Progress Notes, dated 04/27/2021 at 05:53 PM, revealed the Dietitian and Dietary Manager had spoken with the resident on 04/26/2021 for forty-five (45) minutes and the resident had voiced complaints regarding dining services. According to the note, the resident expressed satisfaction with the outcome of the conversation.				Activities director or designee will provide concern/grievance to individual disciplir specific to concern/grievance at next stand-up meeting to investigate and we toward resolution. Beginning on 11/22/2 at daily stand-up meeting mock survey rounds will be reviewed for any concerns/grievances, any concerns/grievances identified will be	de ne ork	
	06/17/2021 at 8:05 PN completed a grievance she was not aware of procedure. The DM s was required to comp form and send the form officer or the administ revealed the DM had January 2021 and was grievance/complaint publications.	ial Worker, on 06/17/2021			presented to individual discipline to investigate and work toward resolution. disciplines who have been presented a concern/grievance will provide update daily in stand-up meeting as they work toward resolution. Social services direct and/or designee will provide proper concern/grievance form to be complete by individual discipline. Social Services director and/or designee will monitor follow up and investigations in daily stand-up meeting. Administrator or designee will review grievances/concern	tor d	
	at 2:12 PM, revealed responsible for review grievances and was n related to food for Res Worker stated she had	ing and investigating ot aware of any complaints sident #156. The Social			weekly beginning 11/1/2021 x4 weeks then monthly for two (2) months with Social Service director or designee to ensure investigation and follow up is completed. Audits will be reviewed		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(F 585)	Interview with the Forthe administrator of re 06/17/2021 at 8:25 Pt Resident #156's food the Administrator, he with the resident to at resident's food complaware grievance form According to the Administrator the complained consider the complained owned often change he Administrator, if grievals	stigations related to food concerns for Resident #156. mer Administrator, who was ecord on 04/26/21, on M, revealed he was aware of complaints. According to instructed Dietary to talk tempt to resolve the aints/concerns and was not is had not been completed. inistrator, he did not its grievance because the often about the food and is/her mind. Per the ance forms were not a potential for the resident's	{F 5	885}	monthly x3 months during QAPI meetir then quarterly until in substantial compliance. Criteria 5: Date of compliance: 11/30/2021	ıg	
{F 600} SS=E	employment at the factor The Administrator star morning meetings star with grievances and his Social Worker, were regrievances. The Administrator Star Grievance should be for Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom from Exploitation The resident has the inneglect, misapproprial and exploitation as defincludes but is not limited.	M, revealed she started cility in early June 2021. Ited this week during the ff had discussed concerns now staff, including the not investigating the inistrator stated all orwarded to her for action. Neglect M Abuse, Neglect, and right to be free from abuse, ition of resident property, affined in this subpart. This	{F 6	00)			12/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER	,	S1 20	REET ADDRESS, CITY, STATE, ZIP CODE 10 NURSING HOME LANE IKEVILLE, KY 41501	09/.	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
{F 600}	treat the resident's m §483.12(a) The facilit	ical restraint not required to edical symptoms. y must- e verbal, mental, sexual, or or or or or or or or or or or or or	{F €	600}			
	by: Based on observation and review of the facility failed to have the facility failed to have the facility failed to have the facility residents were free for #82, #86 and #322). Interviews and record admitted Resident #82 admission, the resident resident werbally/physically at However, the facility interventions to preveabusing other resider behaviors resulted in incidents and on 05/1 grabbed Resident #3	d reviews revealed the facility to 2 on 05/12/2021 and since ent exposed him/herself their residents, wandered			F 600 Free from Abuse and Neglect Criteria 1: a) Resident #82 was discharged on 8/9/21. b) Residents #64, #86, an #322 were reassessed by the regional Director of Nursing via observation for new skin impairments, withdrawn and crying behaviors and psychosocial of physical signs of abuse on 8-11-2021. There were none identified. Criteria 2: a) All in house residents were reassessed by the Regional Director of Nursing, wound nurse or designee via observation for new skin impairments, withdrawn and/or crying behaviors and physical signs of abuse on 8-11-2021. There were none identified. b) On 9-7-21 residents were	or ctor ia	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(F 600)	Continued From page	: 110	(F 6	(00			·
{F 600}	#64's wrist and would Resident #317 held R Resident #82 wander would not leave; On hit Resident #86 with bruise to the resident '07/31/2021, Resident left wrist. Interviews with reside Residents #64, #86 a Resident #82. Intervi 07/27/2021 revealed he/she went to sleep came in his/her room action to protect the material to place to ensure reside has caused or is likely harm, impairment or of Immediate Jeopardy '08/11/2021, and was 03/06/2021, at 42 CF (F580), 42 CFR 483.1 (F600), 42 CFR 483.1 (F692), 42 CFR 483.2 Quality of (F692), 42 CFR 483.4 (F755) and 42 CFR 4 (F880). The facility was Jeopardy on 08/11/2021.	not let go; On 06/30/2021, desident #82's wrist because ed into his/her room and 07/15/2021, Resident #82 a shoe causing a large is upper arm and on #82 hit Resident #64 on the write and staff revealed and #322 were afraid of ew with Resident #86 on he/she was afraid when because Resident #82 still and the facility had taken no esident. In have an effective system in ents were free from abuse, you to cause serious injury, death to a resident. In have an effective system in ents were free from abuse, you cause serious injury, death to a resident. In have an effective system in ents were free from abuse, you cause serious injury, death to a resident. In have an effective system in ents were free from abuse, you cause serious injury, death to a resident. In have an effective system in ents were free from abuse, you cause serious injury, death to a resident. In have an effective system in ents were free from abuse, you cause serious injury, death to a resident. In have an effective system in ents were free from abuse, you cause serious injury, death to a resident. In have an effective system in ents were free from abuse, you cause serious injury, death to a resident. In have an effective system in ents were free from abuse, you cause serious injury, death to a resident. In have an effective system in ents were free from abuse, you cause serious injury, death to a resident.	{F 6	(00)	a diagnosis of dementia had their Care Plan reviewed and revised as necessar by MDS Coordinator. d) Beginning 11-21-2021 licensed nurses and designees perform re-interviews of residents with the most recent BIMS score of 8 or greater to ensure that they feel safe in the facility and if they have any concerns. No residents had any concerns. Interviews were completed 11/22/2021. No conce were identified. e) The Regional Nurse consultant completed a wandering risk assessment on all residents by 8-16-21 All residents who were identified as at for wandering had care plans reviewed and updated by MDS Coordinator. Criteria 3: a) All staff were re-educated by the administrator and/or designee beginning on 8-12-2021 on the processidentifying, preventing, and reporting abuse as well as identifying and implementing immediate interventions wandering residents. b) Beginning 11/24/2021 of CMS Hand in hand Module 1 -5-1. Understandig the world of Dementia: person and the disease 2. Being with a person with Dementia: Listening and Speaking 3. Being with a person with Dementia: Actions and reactions 4. Being with a person with	ry, ned st frns l. risk ed s of	
	verified based on obs	r, the AOC could not be ervations, staff interviews, documentation. Additional			Dementia::Making a difference 5. Preventing and responding to abuse has been added to all staff s electron		
	and review or lacility	accumentation. Additional	1		training system and to the new hire		

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{F 600}	Continued From page	e 111	{F 6	i00}			
	Immediate Jeopardy	was identified at 42 CFR			training requirement. The training will t	ре	i
	483.35 Nursing Servi	ces (F725), 42 CFR 483.70			required for all Parkview staff annually	. All	
) (F837), 42 CFR 483.75			staff will complete all 5 modules by		
	Quality Assurance an				12/30/2022. The DON/ designee will	ı	
		The facility was notified of			monitor completion. New hires will		
		rdy on 09/10/2021. The			complete modules 1-5 in the first 90 da	ays	
	Immediate Jeopardy	is ongoing.			of hire.		
					c) By 11/30/2021 all staff will ta	ke	
		allegation of compliance			a re- test on recognizing abuse and		
		25/2021, which alleged			reporting abuse which will be graded b		
	removal of the Immed 09/26/2021. The Sta				the NHA/DON or designee to establish		1
	determined the Imme				staff competency. Staff not working will		
		during a revisit conducted on			take the quiz on their next scheduled s Staff (including agency and new hires)		
		n lowered the scope and			who do not pass the test with a 100%		
		R 483.10 Resident Rights			be-re-educated and re-take the test un		
		orehensive Person-Centered			score of 100% is achieved.		
		656), 42 CFR 483.25					
		4) (F686), 42 CFR 483.35			Criteria 4: a) During the Ad-hoc QAI	ગ !	
		25), and 42 CFR 483.45			meeting on 08-12-2021, the		
		F755); and to "E" at 42 CFR			Abuse/Neglect policy, wandering		
	483.12 Freedom from	n Abuse (F600), 42 CFR			identification and intervention process	was	:
	483.25 Quality of Car	re (F692), 42 CFR 483,70			reviewed, and audits put in place to		i I
) (F837), 42 CFR 483.75			ensure compliance with this process.		
	Quality Assurance ar				b) On 8-13-21 the		
	Improvement (F867),				administrator and/or designee began a		
	Infection Control (F8				employee verbal staff quiz, 5 employe		
	•	eness of systemic changes			per week were questioned on identifyi		
	and quality assuranc	e activities.			signs/symptoms of abuse, when to rep	ort	
	M*1 21 41				abuse, signs/symptoms of wandering		
	The findings include:				residents and interventions appropriate		
	Davinus of the feetites	'e "Ahusa			wandering residents weekly. Audits wi		
	Review of the facility	's "Abuse live" Policy, last revised in			continue weekly and will be reviewed:	JE	
		ealed the facility would			QAPI monthly and will continue until		
		ct. Per the policy, the facility			substantial compliance is achieved. c) Beginning 09-01/2021 the Director of	, f	
		doing all, that was within its			Nursing or designee will review each	Л	
		currences of abuse and			resident's wandering risk assessment		
		the policy, abuse was			upon admission and readmission.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
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{F 600}	deprivation by an indicaretaker, of goods onecessary to attain or and psychosocial well stated verbal abuse with gestured language the disparaging and derotheir families or within regardless of their agdisability. Sexual abuse with a resident and not facility's failure to provesident, which were harm, pain, mental are The policy also stated actions to prevent abuncluded identifying, osituations in which abund developing a care appropriate intervention of abuse. Examples of and suspicious bruisin unknown origin. The Administrator was resofthe policies/proced and neglect in the factility's Status (BIMS) list for Resident #322 was in score of twelve (12) a interviewable with a EThe list also indicated was eight (8).	infliction of injury, and vidual, which included a reservices which were remaintain physical, mental libeing. The policy also was the use of oral, written or at willfully included gatory terms to residents or a their hearing distance, e, ability to comprehend or use was defined in the policy exual contact of any type eglect was defined as the wide goods and services to a necessary to avoid physical eguish or emotional distress. If the facility would take use in the facility which correcting and intervening in the plan that identified ons to prevent occurrences of abuse, per the policy, resident to resident abuse and, and any injury of policy also stated the sponsible for implementation ures which prohibit abuse	{F 6	00}	Residents identified as a risk for wandering will be brought to the clinical morning meeting for review and initiation of new interventions. Any variance or identified concerns will be addressed immediately. New interventions will be care planned in the morning meeting by the Director of Nursing, Assistant Director of Nursing or nursing designee weekly then monthly x2. Audits will be reviewed QAPI monthly x3 months and then quarterly until in substantial compliance d) Starting 7-26-2021 the Social Services Director or designee began performing random interviews or residents a week for 4 weeks the 5 residents a week for 8 weeks of resider with a BIMS score of 8 or greater to ensure they feel safe in the facility and have not witnessed or been subjected abuse. Audits of a minimum of 5 reside a week will continue until compliance is achieved. Any reports of abuse will be immediately reported to the Administrativith initiation of the investigation. Audit will continue weekly and will be reviewed at QAPI monthly x 3 moths and then quarterly until in substantial compliance e) Beginning 11-1-2021 reside to resident incidents will be audited weekly to ensure interventions have be put in place to protect resident safety a are care planned. Audit will continue weekly and will be reviewed at QAPI monthly x3 months and then quarterly until in substantial compliance. f) Beginning 11-22-21 DON designee will review random weekly sk assessments for residents with a BIMS assessments for residents with a BIMS assessments for residents with a BIMS assessments for residents with a BIMS assessments for residents with a BIMS assessments for residents with a BIMS assessments for residents with a BIMS assessments for residents with a BIMS assessments for residents with a BIMS assessments for residents with a BIMS assessments for residents with a BIMS assessments for residents with a BIMS assessments for residents with a BIMS assessments for residents with a BIMS assessments for residents with a BIMS assessments for residents with a B	y tor x4 d at at a sor sed e		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PE	ROVIDER OR SUPPLIER			_	STREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021	
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(F 600)	Continued From page	e 113	{F 6	00}				
	with behavioral disturb Disease.	uded Unspecified Dementia bances and Parkinson's		,	score of less than 8 to ensure there are no injuries of unknown origin. 5 random residents will be audited weekly until substantial compliance, then monthly x Any variance or identified concerns will	2.		
	Review of Resident 8. Set (MDS) assessme	2's Quarterly Minimum Data nt, dated 07/14/2021.			addressed immediately. Audits will be reviewed at QAPI monthl			
		ssessed the resident to have			x3 months and then quarterly until in	,		
	a Brief Interview for M	lental Status (BIMS) score			substantial compliance			
		een (15), indicating the			g) Beginning 12/3 /2021 a			
		viewable. According to the	1		member of the governing body is on sit			
	MDS, Resident #82 h		i		daily. The governing body member will			
	directed towards othe				review the resident interviews to ensure	-		
		three (3) days during the			that any interviews indicating abuse or			
		lesident #82's MDS also			neglect has been investigated and		l	
		ired extensive assistance of			reported as required.			
		when transferred between						
	surfaces and walking.	,						
	B-1				Criteria 5: Date of compliance:			
		82's Comprehensive Care			12/30/2021			
		20/2021, staff identified the						
		symptoms that were not						
		s: wandering, agitation and physically/verbally abusive						
		Physically/verbally abusive Resident #82's care plan						
	also revealed he/she							
		wandered into other sometimes urinated. Further						
		n revealed interventions						
		021 included to approach						
		ietly, attempt to discover						
		uch as pain, wants, needs						
		r medications and review						
		ed, psychiatric consults and						
	send to hospital as ne	eded. Further review						
		Resident #82 exhibited						
		the facility, the only time						
		I his/her care plan was on						
		erventions were added for						
		ting needs, thirsts and						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED		
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{F 600}	the resident was wan going in/out of other resident was wan going in/out of other resident was the resident of the resident was revealed staff another resident bathroom while he/sh review revealed where to remove the other resident #322's arm centimeter (cm) x 1 cm. Review of Resident # revealed no documer reported on 05/18/20. Interview with Resident #8 approximately 12:30 afraid of Resident #8. "a while back" Resident #8. "a while back" Resident #322's arm skin. Resident #322's arm skin. Resident #322's to staff he/she was a Continued interview relation also exposed him/he had tried to get in the multiple occasions. Inothing had been do and Resident #82 stil room.	ted of Resident #82, on PM and at 4:20 PM, revealed dering in the facility hallways resident's rooms. Ident report dated 05/18/2021 Resident #322 reported to wandered into his/her rewas "in there". Further in Resident #322 attempted resident, he/she "grabbed" which resulted in a 1 m skin tear to his/her arm. 182's medical record red evidence of the incident 21. 181's medical record red evidence of the incident 21. 182's nedical record red evidence of the incident 21. 182's medical record red evidence of the incident 21. 183's medical record red evidence of the incident 21. 182's medical record red evidence of the incident 21. 184's medical record red evidence of the incident 21.	{F €	600}			

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NAME OF PE	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/-	3012021	
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{F 600}	the incident report for resident reported to hinto his/her bathroom. he/she attempted to rhis/her bathroom the arm and caused a ski acknowledged the incresident abuse and stincident immediately (Nursing (ADON). How direct staff to take any further incidents of reconcerning Resident: Resident #82 has con Resident #322's room rooms and also stated #64 and Resident #86 were fearful of Resident #86 were fearful of Resident #82 exhibited abusive residents in the facility about the incident that with Resident #322, sincident and acknowle incident to her. The Awas an allegation of rand interventions sho to protect resident for stated no action was reported the incident to Stated was no longer employ	M, revealed she completed Resident #322 when the er Resident #82 wandered . The resident reported emove Resident #82 from resident grabbed his/her in tear. The RN cident was resident to tated she reported the to the Assistant Director of evever, the ADON failed to y actions to prevent any sident to resident abuse #82. RN #1 stated attinued to wander in/out of in, as well as other residents de Resident #322, Resident for verbalized to her that they ent #82. Sistant Director of Nursing eter of Nursing, on DM, revealed she initially e was not aware Resident e behaviors towards other y. However, when asked at occurred on 05/18/2021 she was able to recall the edged staff reported the ADON stated the incident resident to resident abuse build have been implemented om abuse; however, she to the Administrator at the urred, but was unsure if he te Agencies or not and he yed at the facility. According	⟨F €	600}				
	to the ADON, she wa	s not responsible to report						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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{F 600}	was responsible to in abuse, but had not in because she was not 2. Continued review record revealed on 05 on 05/22/2021 at 3:25 to wander in/out of ot was "becoming verbaresidents." Interview with RN # 1 revealed she made a medical record on 05 resident being verbal residents. She stated wandering in other reand argue back" with were asking Resident space. She could not involved "that was a shad not filled out an instated she reported to stated she was not diprevent further abuse Interview with RN # 9 revealed she docume behaviors on 05/22/2 abuse towards other ongoing since he/she and Administrative st his/her behaviors. Cresident #82 wander personal space "cons redirect. She stated	State Agencies; however she vestigate allegations of vestigated this incident directed to do so. of Resident #82's medical 5/21/2021 at 10:20 AM and 9 AM, the resident continued her resident's rooms and ally abusive with other , on 07/30/2021 at 9:50 AM, n entry in Resident #82's /21/2021 regarding the ly abusive with other dithe resident was sident rooms and would "yell the other residents, as they at #82 to exit their personal recall which residents were while back" but stated, she incident report. The RN he abuse incidents to emember who;" however, rected to take any actions to be from occurring.	{F 6	00}			

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		185256	B. WING			09/	30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
{F 600}	and ask him/her to let #82 "yells and makes the other residents." had not filled out incid witnessed events, but to the previous Admin and the Administrator however, nothing had further abuse from occeptable of Resident #revealed, on 06/02/20 by the facility Psychia since admission. Revindicated the resident behaviors and confus indicated the resident treatment" and recommonitor/document an evidence of psychosis status, mood, behaviors. Review of Resident and when staff evaluationing from, Reside Resident #64's room #64's wrist and arm a of the incident revealed Resident #82's hand and physically assist #64's room because to the hospital for an 06/04/2021 and when 106/04/2021 and when 106/04/2021 and when 106/04/2021 and when 105/04/2021 and 105/05/2021	pset due to this behavior, ave their rooms, Resident growling noises and scares According to the RN, she dent reports related to the at the incidents were reported distrator, the current ADON "too many times to count"; been done to prevent curring. 82's medical record 221, he/she was evaluated stry services for the first time view of documentation initial complaints were ion and the findings was "compliant with current smendations were made to y associated side effects, and/or changes in mental or, sleep, or appetite. ht #82's facility reported (2021, revealed at 1:15 PM coming from the hallway ated where the noise was	{F €	600}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING			R 09/30/2021	
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	1 0.727 District To 17	LD BE	(X5) COMPLETION DATE	
(F 600)	fifteen (15) minute chevery thirty (30) minute and every hour for twell approximately thirty-osign was placed over facility psychiatrist was Resident #82's behave Review of Resident #revealed on 06/04/20 someone "yelling" and see what was worth observed in another rhad his/her "hand was residents right forearmed in the record resident specified) "we "staff had to remove" resident back to his/her revealed the resident hospital on 06/04/202 Review of Resident #revealed the resident 06/05/2021 at 6:30 All was to be on an increase review of the nurses recontinued to wander in rooms and was difficuted to the record revealed Resident #82 was "was residents and trying the female" and the residents rooms screaming." Continued to consider the residents rooms screaming." Continued to consider residents rooms screaming."	ed level of supervision; every ecks for seven (7) hours, tes for twelve (12) hours, elve (12) hours (totaling one (31) hours), and a stop Resident #64's door and the is ordered to evaluate viors. 82's medical record 21 at 1:10 PM, staff heard di when staff "went to check ong" one resident was esidents room and he/she apped around" the other in and wrist. Continued evealed the resident (no ould not lessen grip" and his/her hand and assist the er room. The record also was transferred to the interest at 2:10 PM. 82's medical record returned to the facility on index revealed he/she in/out of other resident's ased level of supervision, notes revealed he/she in/out of other resident's at 8:30 AM on 06/05/2021, alking in front of other or grab them both male and ent continued to wander into a and "they start yelling and end review of Resident #82's led the resident continued to it residents rooms on	{F 6	500}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			R	
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	<u> 09/</u>	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	12:45 PM, revealed he Resident #82 and he/resident, and had rep staff. However, the redone to protect him/he Resident #82 wander "grabbed my arm and resident stated Resid in/out of his/her room anything to stop" him/me again." Review of Resident #revealed he/she was psychiatric services a his/her chief complair wandering/inappropria was hard to redirect, thad a history of violer According to the evaluation of the resident recommending in the resident recommending in the resident recommending in the resident recommending in the resident recommending in the resident recommending in the resident recommending in the resident recommending in the resident recommending in the resident recommending in the resident recommending in the revaluation changes with the evaluation. Interview with Registe 07/30/2021 at 9:50 Affine in the resident recommending	e/she had been abused by she was afraid of the orted his/her fear to facility esident stated nothing was er and even though ed into his/her room and wouldn't let go". The ent #82 continued to wander at times, and "no one does her from coming "in here on 82's medical record evaluated by the facility gain, on 06/14/202,1 and ats were at behaviors, the resident falked to him/herself and the towards others. The uation, the resident's family a history of violence and dent would become "wild as redirect and he/she went oms and residents were and Resident #82. Indicated the residents dations was "psychiatric ent." However, no were recommended during ered Nurse (RN) # 1, on M, revealed she was dent occurred with Resident and she notified the ated even though the	⟨F €	600}			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG		-		R	
NAME OF PI	ROVIDER OR SUPPLIER			_	STREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021	
PARKVIEV	V POST-ACUTE AND RE	HABILITATION CENTER			200 NURSING HOME LANE PIKEVILLE, KY 41501			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	-	(X5) COMPLETION DATE	
{F 600}	Continued From page	e 120	{F 6	500	}			
	continued. The RN s he/she was afraid of I resident continued to	day, his/her behaviors tated, Resident #64 reported Resident #82; however, the wander in/out of other no actions had been taken ts.	,	•				
	the facility reported the 06/04/2021 which involved Resident #64. Accord RN #1 heard a noise and when the nurse volved Resident #82 in Resident #82 in Resident had hold of Fand would not let go. removed Resident #8	2 from his/her room and e hospital for an overnight						
	dated 06/04/2021, rev "substantiate the alleg "did in fact hold on to' not able to be redirec "non-injury to residen recommended psychi	gations" that Resident #82 "Resident #64's wrist, was ted which resulted in t" #64. The facility iatric services to evaluate ors. The report failed to						
	on 06/30/2021 Reside Resident #317's room asking the resident to Resident #317 was "h wrist. Staff escorted F room. According to the	reported incident revealed ent #82 wandered into n. Resident #317 was leave his/her room and nolding onto" Resident #82's Resident #82 out of his/her he facility reported incident, at they did not substantiate						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R
NAME OF P	ROVIDER OR SUPPLIER	150200	0. *********	S	TREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER		20	00 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	abuse between Reside Continued review of to "medical condition of Disease" Resident #8 room, looking for" his transferred to the host treatment. Review of Resident # revealed the resident inpatient psychiatric is returned to the facility according to staff ther Resident #82's behave from the hospital stay 5. Review of Resider revealed, on 07/13/20 #86 called the State F was coming in his/her him/herself. However revealed RN #1 informour residents had Der wander". Per the receptive a resident had him/herself to Resident also documented she Resident #86 "has be Interview with Registe 07/30/2021 at 9:50 Al working on 07/13/202 contacted the State P incident were reported however, no actions he the resident or to inveallegation. She stated the incident had not o	lent #82 and Resident #317. he report revealed due to Dementia and Alzheimer's 12 "inadvertently entered ther room and he/she was pital for evaluation and 82's medical record was transferred to an tay on 07/01/2021 and on 07/08/2021; however, re were no changes in riors when he/she returned 1. 11 #86's medical record 121 at 11:15 AM, Resident Police because Resident #82 room and was exposing r, review of the record med the Police that "95% of mentia and some do cord, the RN informed the not been exposing nt #86 or others. The RN informed the Police en known to exaggerate." Pered Nurse (RN) # 1, on M, revealed she was 1, when Resident #86 olice. The nurse stated the did to the Administrator; had been taken to protect	{F 6	00}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			1			1	R
		185256	B. WING			09/	30/2021
	ROVIDER OR SUPPLIER **POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	· · ·	
(X4) ID PREFIX TAG			PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	have been reported/ir interventions should in protect the resident. 6. Review of Resident incident, dated 07/15/#82 wandered into Resident to leave the residents incident report, Resident report also indicated a implemented to prevente into his/her room, how frequently takes it do the investigation revenue Resident #82 was about the report also stated further abuse was the report also stated further abuse was the report also stated further abuse was the report also stated further abuse was the report also stated further abuse was the report also stated further abuse was the report also stated further abuse was the report also stated further abuse was the resident #82 had was room and "picked up" According to the reconstaff that he/she was resident woke up, the room and the resident he/she was going to him/her and also inforget" him/her "before" medical record also reinformed staff his/her	ation of abuse which should he he stigated and have been implemented to at #86's facility reported (2021, revealed Resident esident #86's room and #86's shoes and then turned room. According to the ent #86 pressed his/her led by the facility and threw (2. Documentation on the astop sign had been ent residents from wandering ever Resident #86 www." Continued review of aled the facility determined used by Resident #86, and steps taken to prevent at the facility would #86 to keep his/her stop sign in her room. 86's medical record, dated at approximately 5:50 PM andered into Resident #86's the residents shoes. The resident was in her to stated "I was afraid" at the facility would the stated "I was afraid" at the stated "I was afraid" at the stated "I was afraid" at the stated "I was afraid" at the stated "I was afraid" at the stated "I was afraid" at the stated "I was afraid" at the stated "I was afraid" at the stated Resident #86 stop sign was not in use at at, and he/she stated he/she	{F 6	600}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						ſ	R
	<u> </u>	185256	B, WNG	_	 _	09/	30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER	:	2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
{F 600}	o7/27/2021 at 1:00 Pt was in place and no p on the resident's pers residents from enterin observations revealed approximately 6 x 8 in in color to the resident resident informed the the bruising when Resident informed the the bruising when Resident informed the the bruising when Resident informed the the bruising when Resident facility was not try resident did not know resident stated Resideroom, "beat me up" alliked it". Per the resident since Resident facility. The resident incidents to facility stately helping me. Resident even contacted the Pedone anything" to help also stated he/she was the opposite end of the away from him/her; he continues to come in/after he/she was hit b #86 stated, on 07/15/5 his/her bed and Resideroom again, exposed and picked up the resident in the state of the stated in the state of the stated in the	ted of Resident #86, on M, revealed no stop sign personal alarm was in use on, to prevent other in the large bruise, inches in size, and red/purple it's left upper arm. The surveyor he/she sustained sident #82 hit him/her with a sident #86, on 07/27/2021 at M, revealed he/she felt like ing to help him/her, and the what else to do. The ent #82 entered his/her and then "asked me how I lent, Resident #82 had the resident numerous #82's admission to the stated he/she reported the side, but again, "no one has the resident. The resident is "moved down here" (to e hall) to keep Resident #82	{F €				
	stated he/she threw w	rater on the resident to get room, and he/she reported					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		185256	B. WING				R
NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND	REHAB	ILITATION CENTER	<u> </u>	2	TREET ADDRESS, CITY, STATE, ZIP CODE ON NURSING HOME LANE PIKEVILLE, KY 41501	[09/	30/2021
PREFIX (EACH DEFIC	ENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
him/her again; ho taken to protect he Resident #82. Interview with Sta (SRNA) #16, on Cared for Resident personal belonging other residents. Thad been exposing for "a long time." been reported to contacted the fact were instructed to when he/she "had because the resident when he/she "had because the resident moved, Resident the resident's room him/herself to the incidents continue staff, which inform to ongoing concern however, no action Resident #86 or catated she worked beginning on 07/10 occurred between #86. She stated approximately 6.3 the incident and shis/her room, exp	ent #82 vever, rm/her fr e Regis 7/27/20: dent #8 he facili s rooms gs and de facili s rooms gs and de facili s rooms gs and de facili s rooms gs and de facili s rooms gs and de facili s rooms gs and de facili s rooms gs and de facili s rooms gs and de facili s rooms gs and de facili s rooms gs and de facili s and come get the resident de facili s had the facility had the faci	exposed him/herself to to actions have been om further abuse from Itered Nurse Aide 21 at 8:10 PM, revealed 2 since he/she has ty and he/she wandered 5, "picks up their" exposes him/herself to A stated Resident #82 erself to Resident #86 ted the concern had inistrator; however, staff resident #86's room anything wrong," ided across the hall incident occurred, 2021. According to the esident's room had been tinued to wander in/out continued to expose 1. SRNA #16 stated reported to nursing SRNA they had reported e Administrator; been taken to protect om abuse. The SRNA ht shift (6 PM-6 AM) after the incident out #82 and Resident	{F (600}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		405756	D MANG			1	R
		185256	B. WNG	-		09/	30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		200 NURS	DDRESS, CITY, STATE, ZIP CODE SING HOME LANE LE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
{F 600}	his/her shift, and she to Licensed Practical the Administrator was incident occurred; how questioned about the the surveyor. According #82 continued to wan rooms and no actions residents from abuse. Interview with SRNA #PM, revealed he/she is on 07/15/2021 and ob "knot" to Resident #86 SRNA stated Resident #82 entered his/her rotthe resident and hit the SRNA stated Resident into other resident's rothad reported, on num #82 exposed him/hers wandered in/out of his actions were taken to SRNA stated he/she of Administration "punish Resident #86's fault, of the first time the resident SRNA, the resident's freported to LPN #8. Interview with LPN #8 revealed she worked in 07/15/2021 when the also stated the incider arrived for her shift. Si #86 informed staff Resident #86's informed staff Resident staff Resident at the incider arrived for her shift. Si #86 informed staff Resident sta	arm at the beginning of reported the resident's injury Nurse (LPN) #8. She stated on the unit after the wever, she had not been incident until questioned by ing to the SRNA, Resident der in/out of other resident's were taken to protect #18, on 07/27/2021 at 10:00 also worked the night shift in the served a large bruise and a 5's left upper arm. The int #86 reported that Resident from, exposed him/herself to be resident with a shoe. The int #82 frequently wandered froms, and Resident #86 reported that Resident self to the resident and softer room; however, no protect the resident. The could not understand why med" and "acted like it was" respecially since this was not	{F 6	00}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WNG				R	
NAME OF P	ROVIDER OR SUPPLIER	103230	0.441140	CTD	ESTADDRESS CITY STATE NO CORE	09/	30/2021	
	W POST-ACUTE AND RE	HABILITATION CENTER		200	EET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE EVILLE, KY 41501	_		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE	
{F 600}	reported a large bruis she observed and rep ADON; however, the any interventions to p Interview with the ADON ursing, on 08/11/202 aware Resident #86 whowever, stated she to "afraid in general in the his/her fear was unrel he/she "just didn't like stated she came to the Resident #82, wande room; however, stated Resident #86 reported exposed him/herself to any other day. She as her of a bruise on Resident #86 had been observed. Resident #82 entered 07/31/2021 at approx through the residents when Resident #64 as	oe. She also stated staff e on Resident #86, which borted the bruising to the ADON failed to implement rotect residents from abuse. ON/Interim Director of 21 at 12:00 PM, she was vas afraid of Resident #82; hought the resident was just le facility" and felt like lated to Resident #82, and "Resident #82. She also e unit, on 07/15/2021, when red into Resident #86's d no one informed her d to staff Resident #82 o the resident that day, or lso stated staff had notified	{F €	500}		of.		
	the right wrist. According to a rea was observed and again on 08/02/21 she provided cared to was admitted to the fahis/her abusive behaviored area.	ding to the record, a small d to his/her right wrist. on 07/29/2021 at 9:30 PM, 021 at 2:00 PM, revealed Resident #82 since he/she exility in May 2021, and vior towards staff and other portinuous since admission.						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							R
		185256	B. WNG			09/	30/2021
NAME OF PI	ROVIDER OR SUPPLIER			П	STREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	V POST-ACUTE AND RE	HARII ITATION CENTER			200 NURSING HOME LANE		
		TABLETATION CENTER			PIKEVILLE, KY 41501		
(X4) ID		ATEMENT OF DEFICIENCIES	ID.	_	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)		COMPLETION DATE
{F 600}	Continued From page	± 127	{F 6	600	D}		
	The RN stated Reside	ent #82 had wandered in/out	`				
	of other resident's roo	ms, "yelled/growled" at					
	other residents and cr	reated fear in others. She					
		#64, Resident #322 and					
	Resident #86 had rep	orted they were afraid of					
	Resident #82 and eve	en though the concerns have					
	been reported to the						
		e than one occasion, no					
	actions have been tak	en to protect the residents.					
		ed sometime in June 2021, a SRNA reported to her that					
		d staff that Resident #82					
		o the resident. According to					
		the resident's allegation to					
	the Administrator and	the Administrator instructed					
		lent #86 to the other end of					
		residents resided across the					
		She stated Resident #86					
	was moved as directe	d by the Administrator;					
		2 continued to wander					
		/her room and expose					
		Iso hit Resident #86 with a					
	shoe, resulting in a lai	rge bruise and a hematoma					
	Since ne/sne had beer	n moved. According to the					
	room and hit the regid	ndered into Resident #64's					
	She stated Resident #	ent again on 07/31/2021. #64 was already afraid of the					
		she had previously hit the					
		ne assessed Resident #64					
		ne incident occurred, the					1
		." The 07/31/2021 incident					
		dministrator, and the RN					
	was instructed to keep						
	however, the RN state	ed she informed the					
	Administrator due to s	taffing, that was not					
	possible, and no furth	er direction was taken to					
	protect the residents.						
	Review of nursing doc	cumentation, on 08/01/2021					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R 30/2021
_	ROVIDER OR SUPPLIER **POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501	007	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	Interview with the ADO Nursing, on 08/11/202 worked at the facility of year and had just been interim DON within the stated since being AD worked the floor as a had been able to concomplete any monitor residents. She also seystem in place to mowhich could result in rincidents; however, store from abuse in the afraid. Interview with the Ado 6:00 PM, revealed she Coordinator and was informed staff he/she However, the Administ Resident #86 targeted stated she felt the self-inflicted. When a had implemented to efree from abuse in the provided the resident ring when incidents on a stop sign at his/her refused to utilize the inothing else had beer resident or to help him She acknowledged here.	#82 was alert, and s," approximately 10 hours ent #64 for the second time. ON/Interim Director of 21 at 12:00 PM, she had for approximately one (1) on moved into the position of e last few weeks. She also ON at the facility, she had staff nurse, more than she duct morning meetings, or ing in the facility for the tated the facility had no unitor resident behaviors resident to resident abuse rated residents should be e facility and should not be ninistrator, on 08/11/2021 at e was the Abuse aware Resident #86 was afraid of Resident #82.	{F €	600}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		185256	B, WING			R
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP (200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE	09/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIA	(X5) COMPLETION DATE
{F 600}	asked what interventic to protect other reside Resident #82 she stall him/her somewhere e wanders. She also splace to monitor reside because thiswas a "nustated meetings were to discuss nursing issure who attended the the ADON frequently nurse due to short stashe stated she had not meetings since she be 06/07/2021 because "and she had "a lot of it "The facility alleged to implemented to remove effective 09/26/2021: 1). Braden Scale Asseon all residents by fact and comprehensive fureview and update can had pressure injuries and comprehensive fureview and update can had pressure injuries and comprehensive fureview and update can had pressure injuries and the facility utilized the sand comprehensive fureview and update can had pressure injuries and update all current to the Medical D 09/17/2021.	buse incidents, and when ons had been implemented ents from abuse, as well as led, "I can attempt to place" also because he/she tated she had no system in ent's behaviors in the facility ursing thing." She also being held Monday-Friday ues; however, she was not ose meetings. Per interview worked the floor as a staff offing in the facility. Further of attended any of those ecame Administrator on this place is such a mess" assues in the facility kitchen." The following was be a limited assessments are completed either the facility nurses on 08/28/2021 all body skin assessments are sidents on 09/11/2021. The Braden Scale Assessment to be plans of residents who by 09/17/2021. The province of the plant of the sident taff assessed and	{F €	500}		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		185256	B. WNG			R	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 200 NURSING HOME LANE PIKEVILLE, KY 41501	CODE	09/30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD B		
{F 600}	be completed, and the developed within 48 in pressure ulcer or pote comprehensive care particles of admission or potential pressure interventions to prever development or worse. 4). Residents #45, #6 and #320 were bathed care and moisturizing and assisted with drectothing. Clean linear residents' beds on 09 were evaluated by so. 5). All residents were interviewed to obtain by the Director of Nur. New bath/shower sch. by nursing staff to accomprehence. Resident were obtained and incomplans and State Registicare plans by the Registicare plans by the Registicare plans and State Registicare plans by the Registicare	den Scale assessment will be baseline care plan will be nours to include any ential for pressure ulcer. A plan will be developed within to include pressure ulcers ulcers and include ent pressure ulcer ening of pressure ulcers. 5, #308, #309, #311, #314 d including a shower, nail lotion applied post shower, ssing in clean appropriate s were placed on the //1/2021. The residents cial services on 09/15/2021. offered a shower and shower/hygiene preferences sing (DON) or designee. edules were implemented commodate resident preferences for hygiene corporated into resident care stered Nurse Aide (SRNA) gional Nurse Consultant 9/13/2021. de Registered Dietitian (RD) esidents' diets and made meal changes or ote healing and to address	{F €	500}	2.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						F	₹
	<u></u>	185256	B. WNG			09/3	30/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PARKVIEV	N POST-ACUTE AND RE	HABILITATION CENTER		2	00 NURSING HOME LANE		
I AMINAILI	T FOOT-ACCITE AND NE	TABILITATION CENTER		P	PIKEVILLE, KY 41501		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	v	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
{F 600}	Continued From page		{F €	(00			
	with no concerns wer 08/13/2021.	e identified completed				:	
	8). The Regional Nurs	se reviewed all residents					
		se monitoring by 07/30/2021					
		nded to include mandatory					
	entry of glucose value						
	Administration Record	u (MAK).					
	9) The Regional Cert	tified Dietary Manager					
		meal service for breakfast,					
'		09/11/2021, all three meals					
	were delivered on tim						
	10). Direct Care staffi	ing was increased through					
	recruitment efforts wi					1	
		ency and travel contracts.				-	
	Direct care nursing st	aff schedules for the next					
		daily by the Director of					
		inistrator to ensure staffing					
		o meet the acuity of the					
		vill be validated as present					
	on the unit at the star	•					
	Director of Nursing, N	nursing Supervisor, gnee. Direct care nursing					
		eplaced by calling other					
		if they can fill the opening,					
	and/or calling agencie						
		e opening. If direct care staff				1	
		ne Director of Nursing,					
	Assistant Director of	Nursing, or member of the					
		team will fill the shift. If					
		evels cannot be met, the					
		esident care that can be					
		rgency staffing, prioritize					
	required task including						
		ers- sponge baths, care					
		nt residents, turn residents meals served timely, and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	HABILITATION CENTER		S 20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	<u> 09/</u>	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
{F 600}	through recruitment estaffing levels have be meals are prepared as 12). On 08/11/2021, as #86 and #322, were rand physical forms of for Mental Status (Blf above and skin integribles BIMS less than eight Licensed Nurse. Resist Dementia had their Corevised, as necessary (MDS) Coordinator or residents were identificated psychosocial and/or presidents were identificated at risk for wandering risk asses 08/16/2021. All reside at risk for wandering updated by the MDS identified active wand placed at each nursing potential interventions 14). Residents #39, #332 were weighed by Registered Dietician in comprehensive nutritice recommendations were recommendations by (DON) or designee, sp Medical Doctor (MD)	acreased dietary staffing fforts and appropriate een achieved to ensure and delivered timely. All residents including #64, eassessed for psychosocial abuse with Brief Interview MS) score of eight (8) or aity reviews for residents with (8) were completed by dents with a diagnosis of are Plan reviewed and aby the Minimum Data Set on 09/07/2021. No new are died as indicating any obysical harm. Arse Consultant completed a sment on all residents by ents who were identified as that care plans reviewed and Coordinator. A list of all ler risk residents were ag station with a list of a for nursing to reference. All 181, #90, #330 and by 09/17/2021. The (RD) completed a son assessment and RD	{F 6	600}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501	03/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)				(X5) COMPLETION DATE
{F 600}	the tray card. The Re Director of Nursing (Din electronic medical record and tray card rinformation on 09/17/. 15). Beginning 09/15/snacks to all residents afternoon by the restoraides, or designee. Sphysician will be docuaide, dietary aides and 16). The facility evalue 08/11/2021, located of for compliance with Complemented yellow a identified two (2) residexposed to positive rewas designated with a barrier and those two this zone on 08/11/2017). The facility had the red zone on 08/11/2017. The facility had t	ronic medical record and on gistered Dietician and ON), reviewed diet orders record to ensure both the effected accurate 2021. 2021, staff began offering and brative nurse aide, activity macks ordered by a simented by the restorative d/or licensed nursing staff. ated the COVID-19 unit on the 5th floor of the facility DC guidelines and and red zones. The DON dents who had been esidents and a yellow zone erection of a plastic zip wall (2) residents were moved to 21. aree (3) residents who were and the per facility policy and sidents #327, #328 and #329 antine per facility policy and sidents #311 and #314 per COVID-19 policy and sidents #311 and #314 were for testing were tested for to 1021. The facility did not is based on the employee and 109/17/2021. The facility on 109/17/2021. The facility	{F 6	600}			

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	R		(X2) MULTIPLE A. BUILDING _	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	F CORRECTION	AND PLAN OF
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE				185256		
200 MUDSING HOME LANG	09/30/2021	TREET ADDRESS, CITY, STATE, ZIP CODE		100200	PROVIDER OR SUPPLIER	NAME OF P
PARKVIEW POST-ACUTE AND REHABILITATION CENTER PIKEVILLE, KY 41501		00 NURSING HOME LANE IKEVILLE, KY 41501		HABILITATION CENTER	W POST-ACUTE AND RE	PARKVIE
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	DBE COMPLETION	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	PREFIX	Y MUST BE PRECEDED BY FULL	(EACH DEFICIENCY	PREFIX
(F 600) Continued From page 134 (F 600) 19). The facility was conducting ongoing surveillance lesting as recommended for COVID-19. Positive COVID-19 residents will be placed in Isolation zone (red zone) and placed in droplet precautions with use of personal protective equipment. The facility will provide physician notification, family notification and care plan revisions. The DON or designee will review newly positive COVID-19 residents to ensure isolation precautions have been initiated. In addition, any resident exposed will be placed in droplet precaution in isolation zone (yellow). The facility will provide physician notification, family notification and care plan revisions. The facility employee testing protocol will be twice weekly on designated days effective 08/16/2021. The facility requires all staff must be tested on designated days. If the employee is not tested, the facility will not allow the employee to work without a current negative COVID-19 test. During testing, the employee will be tested prior to entering the facility by the Infection Prevention Nurse or designee. All testing dates and times will be posted to the employee page, time clock and common areas. 20). The facility screens all residents once a shift for signs and/or symptoms of COVID-19 and documented on the Medication Administration Record (MAR). The facility implemented monitoring for signs and/or symptoms on all residents on 09/17/2021.		DEFICIENCY)	{F 600}	conducting ongoing is recommended for COVID-19 residents will be the (red zone) and placed in ith use of personal. The facility will provide family notification and care ON or designee will review 0-19 residents to ensure thave been initiated. In exposed will be placed in itsolation zone (yellow). The exposed will be placed in itsolation zone (yellow). The exposed will be twice weekly on other cool will be twice weekly on other objective 08/16/2021. The facility be tested on designated is not tested, the facility will be to work without a current east. During testing, the end prior to entering the in Prevention Nurse or dates and times will be see page, time clock and ensured and the cool of t	19). The facility was of surveillance testing as COVID-19. Positive Covidence in isolation zor droplet precautions with protective equipment. Physician notification, plan revisions. The Donewly positive COVID isolation precautions is addition, any resident droplet precaution in if facility will provide phynotification and care pemployee testing protidesignated days effect requires all staff must days. If the employee not allow the employee not allow the employee negative COVID-19 teemployee will be testefacility by the Infection designee. All testing of posted to the employer common areas. 20). The facility screet for signs and/or symptocumented on the M Record (MAR). The famonitoring for signs an residents on 09/17/20. 21). Resident #9, Res Resident #326 and Rewere reviewed for usa	(F 600)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER PARKVIEW POST-ACUTE AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	09/30/2021
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD FROM THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD FROM THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD FROM THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD FROM THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD FROM THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD FROM THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD FROM THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD FROM THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD FROM THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD FROM THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD FROM THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD FROM THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD FROM THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD FROM THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD FROM THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD FROM THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD FROM THE APPROVIDER'S PLAN OF CROSS-REFERENCED TO THE APPROVIDER	HOULD BE COMPLETION
(F 600) 22). The facility stated all residents will receive their medication as ordered beginning 09/23/2021 and implemented pharmacy and physician notification if any medication was unavailable. The facility will abide by new orders from the physician regarding the unavailable medication. 23). The facility formulated an agreement on 09/23/2021, with the facility's pharmacy to provide the facility with a three (3) day supply of medications that requires the facility's approval for cost authorization while pending cost review. 24). New admissions and re-admissions entering the facility after normal business hours and on weekends will have discharge orders submitted, entered into the electronic medical record and submitted to pharmacy through pharmacy integration. The facility implemented the use of fax transmittal as a backup to the electronic pharmacy integration by entering the order in the electronic medical record to receive medications. If the facility will utilize the emergency medication is a timely manner the pharmacy will be notified, and the facility will utilize the emergency medication kit. If an emergency arises and medication is unavailable, the physician will be notified for substitution and/or new orders. 25). The Regional Nurse Consultant, Director of Nursing, and licensed nursing staff completed an audit of all residents' ordered medications and verified all medications were available in the facility by 09/25/2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		185256	B. WNG			09/	30/2021
	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501				
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{F 600}	ensure compliance with Administrator over The QAPI committee Nursing, Administrator Services Director, Act Maintenance, Dietary Services. 27). The facility appoin Administrator on 09/1 current Administrator will receive guidance from the Regional Director of Colinical Nurse for 30 of the thirty-day oversight Administrative Team of the thirty-day oversight Administrative Team of the thirty-day oversight Administrative Team of the thirty-day oversight Administrative Team of the thirty-day oversight Administrative Team of the thirty-day oversight Administrative Team of the administration has responsibility to direct communicate areas of improvement. 28). The Administrator QAPI Committee revision for call Activities of Daily Living timeliness of meal transportations and repositions are Consultants conducted 09/15/2021 with a conconsultation to review outcomes of the Survey roles of the Governing of the Coverning	audited implementation to the the AOC and all audits. Ersees the QAPI committee. consists of the Director of r. Medical Director, Social tivities, Clinical, Therapy, and Environmental Inted an Interim 3/2021 to replace the The facility's Interimetive daily oversight and gional Vice President or Operations and Regional days. Upon completion of the Regional will audit the Administrator to didaily oversight is needed. Its direct oversight and the concern and process In Medical Director, and the ewed procedures for a lining, answering call lights, and the concern and process In Medical Director, and the ewed procedures for a lining, answering call lights, and the concern and process In Medical Director, and the ewed procedures for a lining on 09/15/2021. Int of Operations, Director of and Regional Nurse did a conference call on a litract company for a	{F 6	00}			

	O TOTT INCOTOR ITE OF	WILDIO/ IID OLIVVIOLO				OMB M	<i>J.</i> <u>U938-U39</u> 1
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER W POST-ACUTE AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 200 NURSING HOME LANE PIKEVILLE, KY 41501		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION	
{F 600}	Infection Control (CO staff at the facility to not turn and reposition recare, prepare and discresidents with eating, effective Pharmacy Sand neglect effectively appropriate ADLS, and QAPI committee. 30). The Administrato Consultant reviewed abeginning 09/16/2021 and/or revisions to the the 09/16/2021 meeting standardized plan to be reviewed as needed agenda included reviewed as needed agenda included reviewed as needed agenda included reviewed as needed agenda included reviewed as needed agenda included reviewed as needed agenda included reviewed as needed agenda included reviewed as needed agenda included reviewed as needed agenda included reviewed as needed agenda included reviewed as needed agenda included reviewed as needed agendals services, conceresident council, and grievances, admission development, vacant orientation, dietary value weight loss, work injuited to serview, pharmacy repusiness office, and a Committee and Medic standardized agenda but not limited to, the meeting.	vication/monitoring tools: VID 19 Isolation), enough nonitor/assess residents, sidents, provide incontinent tribute meals, and assist caring for pressure wounds, ervices, dealing with abuse y, sufficient staff, providing id providing a functioning or and Regional Nurse and revised the QAPI Plan and presented the reviews or QAPI Committee during ing. The facility developed a censure all topics were at the QAPI meetings. The ewing pressure ulcers, Foley ding tubes, contractures, edication usage, risk or control, hospital abilitation management, erns of grievance, activities, family council concerns, ins, discharges, census, staff positions, employee riances, tray audit report,	{F (600}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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{F 600}	on 09/16/2021 regard Governing Body, incluprocedures to be improcedures to be improcesses, the in the QAPI processes, the in the QAPI process, causes with the utilized approaches and, audicalendar. The Admin medical Director of furneetings. 32). The Administrator reports before each Cobeginning 09/15/2021 compliance with the dog/10/2021 survey. Qog/16/2021 to discuss interventions to removimplemented QAPI mr. (4) weeks, as needed Administrator will forwain minutes to the Governincluding the Vice Preside Regional Nurse Considerations. The QAPI mreview. The Administrator of Nursing, A Director, Social Servic Clinical, Therapy, Malenvironmental Servic Clinical, Therapy, Malenvironmental Services.	erations met with the IN, and the Medical Director ling the duties of the Inding setting policy and demented in the facility and nation to other members of During the meeting, the need to participate regularly the need to identify root ation of the five (5) why liting systems per the QAPI nistrator will notify the ture QAPI Committee In will collect all monitoring the Indian to ensure deficiencies cited during the Indian the indian were held on a sabatement and develop we the jeopardy. The facility eetings weekly, times four land monthly. The ward all QAPI Meeting hing Body members, esident of Operations, and the fultant, to review the audit mmittee will review the eetings. Committee for rator oversees the QAPI Committee consists of the dministrator, Medical ces Director, Activities, intenance, Dietary and	{F 6	600}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	<u></u>	USI	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		SHOULD BE		(X5) COMPLETION DATE
{F 600}	materials for QAPI, in QAPI Tool Kit, QAPI a guide to effectively im beginning 09/16/2021 meet quarterly for the reevaluate for frequer 34). The Administrato of QAPI Committee m (4) weeks and, as nee to ensure the quality complies with the star compliance with State is demonstrated. 35). All nursing staff v Director of Nursing, N designee on proper w obtaining, documenting changes to the Regist 09/17/2021. 36). On 09/13/2021, t Dietary Manager (CD Manager on the proviassessment to ensure diet order accuracy, a orders into the electron CDM educated the Diresident diet orders in the nurse enters the communication including diet and text meetings, staff will resprevious day to ensure 37). Therapy provided	cources and education cluding but not limited to the at a Glance, and a resource replement the QAPI plan I. The Governing Body will I upcoming year and noty after one (1) year. If will increase the frequency neetings to weekly for four reded effective 09/16/2021, of care is monitored and hadard of care and re and Federal requirements I were educated by the IDS Coordinator, or reighing techniques, ng, and reporting weight tered Dietician by The Regional Certified M) educated the Dietary sion of timely nutritional red diet order accuracy, on and on when to enter diet onic medical record. The reteary Manager to enter reto the tray care system. If order, the nurse will send a n to the dietary staff, ture. In the morning clinical wiew diet orders from the	{F €	500}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		200	REET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE (EVILLE, KY 41501	09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	chair to bed beginning completed on 09/17/2 and assigned addition and agency contracts turn and reposition all reposition themselves 38). The Regional Dirall nursing staff on proincluding turning and hydration and nutrition to complete and docu assessment, and how dietician, physician, a impairment by 09/17// staff will call or email Physician, and Residence skin changes. 39). The DON or desitimely call light responstaff, including nurses assistants, were provitimely hygiene per the timely toileting, dression clean clothing, and trays. The DON or defacility staff not working returning to work. 40). On 08/31/2021, 1 Nursing educated all Registered Dietician, and the MDS Nurses into the electronic me and interventions. In Director of Nursing educators and interventions. In Director of Nursing educators and interventions.	nt from bed to chair and g on 08/19/2021 and 2021. The facility employed hal staff through recruitment to ensure adequate staff to d residents who cannot s. ector of Nursing educated essure ulcer prevention, repositioning, adequate n, positioning devices, how ament a head-to-toe skin to notify the registered and RP of a new skin 2021. The facility nursing the Registered Dietitian, ent Representative of any gnee educated all staff on the se. In addition, direct care	{F €	600}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY
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	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE PIKEVILLE, KY 41501	1 09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)			(X5) COMPLETION DATE
{F 600}	impairments identified 41). The facility's Res Licensed nurses on ic residents with a chang 08/12/2021. In addition and/or designee educt identifying signs/symphyperglycemia/hypoglidiabetic protocol, doct change in condition, of sugar in the medical riphysician and followin facility licensed nursin work until they have re DON educated all clin of glucose levels on 0 during mandatory in-s 42). Beginning 08/12/2 licensed nurses on co Plan with interventional diabetes and a respirate hours of admission, re copy to the resident a Licensed nursing staff education was notified will not be allowed to re received this educatio 43). Beginning 08/12/2 staff on the facility's "o call-off procedure for the event a person needs dayshift, they are to re supervisor two hours if If staff needs to call of	terventions for any new skin I during their shift. piratory Therapist educated lentifying and assessing ge in respiratory status on m, on 08/12/2021, the DON sated all licensed nurses on shorms of lycemia, the facility's locumentation of blood ecord, notification of the graphysician orders. The leg staff will not be allowed to eccived this education. The lical staff on documentation 8/19/2021 and 08/20/2021 lervices. 2021, the DON educated empleting a baseline Care is and goals relevant to satory diagnosis within 48 eviewing and providing a land/or the responsible party. If not working during the form of the land of ongoing education and work until they have in.	{F 6	600}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE	SURVEY PLETED
		185256	B. WNG				R
NAME OF D	ROVIDER OR SUPPLIER	183230	D. WIIVG			09/	30/2021
	N POST-ACUTE AND RE			20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	not have appropriate immediate supervisor other qualified staff to off. If emergency staff Administrator and/or classistance from staffil working will be in-send 44). All staff were product the process of identify reporting abuse, as wimplementing immediate wandering residents. 45). All nursing staff will be process of identify reporting abuse, as wimplementing immediate wandering residents. 45). All nursing staff will be be be be be be be be be be be be be	ir shift. If the facility does staffing levels, the and/or designee will call replace the person calling fing is required, the designee will call for any companies. Staff not viced upon return to work. In wided re-education by the designee on 08/12/2021 on ving, preventing, and ell as identifying and atteinterventions for the designee on 08/12/2021 on ving, preventing, and ell as identifying and atteinterventions for the designed of the designed on the designed of the desi	{F €	600}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING				₹ 30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501	, 03/	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)				(X5) COMPLETION DATE
{F 600}	47). As of 09/15/2021 completed education obtaining food prefers system, ordering food snack/hydration carts procedures, appropria portion sizes. 48). The Director of Nof Nursing educated in Manager on the procedure and/or implementing frecommendations for 09/17/2021. 49). All staff were production of Norsing educated and/or designed COVID-19 policy/guid donning/doffing Person (PPE), yellow and recommendations for 09/17/2021, the Covid and in the procedurate all staff, incomplete in the procedurate and yellow zones for signs/symptoms or reviewed.	eds of the population. , the Regional CDM with the dietary manager on ences, the facility's tray card I based on menus, stocking state scoop sizes, and/or dursing or Regional Director nurses and the Dietary ess for entering, activating, the registered dietician's dietary orders on vided re-education by the elelines, handwashing, anal Protective Equipment I zones. In addition, the ted, licensed staff on for Covid-19 symptoms 11, the DON/designee luding contract staff, who ring the QAPI meeting on di-19 policy, the donning and doffing PPE, and monitoring residents of the Covid-19 were ed re-education on DN, Regional DON, or ultant to enter COVID-19 orders on all new	{F 6	000}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
		185256	B. WING				R
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE			200	REET ADDRESS, CITY, STATE, ZIP CODE 0 NURSING HOME LANE KEVILLE, KY 41501	09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(x5) COMPLETION DATE
{F 600}	administration, included patient, right dose, right dose, right dose, right dose, right dose, right dose, right dose, right dose, right dose, right dose and power available for administration included cathe medication included cathe medication delivery time ordered medication woutside of the ordered education also included given by the MD, document and new orders from medical record. All off will be provided training the provided training the provided training the emergency in place for ensuring readmitting residents after-hours. 53). The Interim Admin on his contact information to notify if unable shift. 54). The facility will at head-to-toe skin asset.	ing staff have been (5) rights of medication ing right medication, right that time, and right route. The designee educated all working on 09/23/2021 on when a medication was not ration as ordered. The alling the pharmacy to obtain ning the anticipated me, notify the MD if an ill either be omitted or given defined medication time. The ed following new orders umenting the conversation, the MD in the electronic her licensed nursing staff and as scheduled for shifts. The medication kit, the system medications are in-house, or an for new orders for new or an including on weekend and mistrator educated all staff attion and role as the Abuse 13/2021 through 09/17/2021. The on staffing schedules and attion work their scheduled udit weekly resident ssments daily, Monday	{F 6	000}			
		ee (3) months effective they have been completed					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION		SURVEY
		185256	B. WING	B. WNG			
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		200	REET ADDRESS, CITY, STATE, ZIP CODE NURSING HOME LANE (EVILLE, KY 41501	09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	will notify the physicial Responsible Party of and those new interver place to prevent declipate to prevent declip	ent. In addition, the facility an, Registered Dietician, and any new skin impairment entions have been put in ne. Idited all lab supplies for the //28/2021. Audits will be all lab supplies for four (4) //2021 and then monthly for Jursing, Assistant Director of Jursing Supervisor will audit es for daily four (4) weeks then weekly for one (1) w Progress notes for on Monday. The Nursing audits to ensure any new ent identified had a care nclude new interventions. Jursing Supervisor will audit es for daily four (4) weeks then weekly for one (1) w Progress notes for on Monday. The Nursing audits to ensure any new ent identified had a care nclude new interventions. Jursing Supervisor and the supplies for the for four designee began visual assessing hygiene, toileting, ident repositioning. All ally rounding on once each weeks, fifty percent of the for four (4) weeks, and fresidents each shift for four has two (2) shifts, 6:00 AM	⟨F €	600}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		IPLE CONSTRU	CTION	(X3) DATE SURVEY COMPLETED	
	,	185256	B. WNG				R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		200 NURSIN	DRESS, CITY, STATE, ZIP CODE IG HOME LANE I, KY 41501	1 09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B ROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(F 600)	59). On 08/13/2021, the began monitoring resistivation Background Recommendation (SE acute change in respit through Friday in the The facility reviewed a respiratory status for implementation of any Plans were reviewed Audits will be daily for times a week for four 60). The MDS Nurse, began audits on 09/15 completion for all new re-admissions to ensubaseline Care Plan with the residents admitted the MDS Nurse(s) and interventions will be a morning meeting by the morning meeting by the morning designee. 62). Beginning on 08/DON, and/or Designee admissions and re-adcare plans for comple with the resident and/variance or identified immediately. Audits with a section of the plans for comple with the resident and/variance or identified immediately. Audits with the resident and/variance or identified immediately. Audits with a complex plans for complex with the resident and/variance or identified immediately. Audits with the resident and/variance or identified immediately. Audits with the resident and/variance or identified immediately. Audits with the resident and/variance or identified immediately. Audits with the resident and/variance or identified immediately.	th shift for eight (8) weeks. the DON and/or Designee piratory assessments and Assessment and BAR) communications for ratory status Monday clinical morning meeting, any acute change in Physician notification and or physician order. Care and updated as needed. Tone (1) week, then five (5) (4) weeks. DON, and/or Designee 5/2021 of baseline care plan or admissions and pure staff completed the atthin 48 hours of admission. Titted within the last thirty of Diabetes, Chronic by Disease (COPD), the umonia had their baseline and updated as needed by diffor designee. New dided to the care plan in the ne DON, ADON, and/or 19/2021, the MDS Nurse,	{F6	00)			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY LETED
		185256	B. WNG			1	R
NAME OF PE	ROVIDER OR SUPPLIER	103230	0. 11110	s	STREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
PARKVIEV	V POST-ACUTE AND RE	HABILITATION CENTER	_	2	00 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATÉMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPRODE DEFICIENCY)				(X5) COMPLETION DATE
{F 600}	admissions for a weel then ten percent of ac weeks. 63). On 09/11/2021, the designee began audit meal trays to resident All three (3) meals will (3) units daily for two all three (3) units daily (1) meal on all three (weeks. 64). On 08/15/2021, the began audits of staff's quiz of identification a with a change in respisions/symptoms of hy the facility's diabetic penange in a resident's physician and followin Leadership will quiz shifts; ten (10) staff for staff a week for four (4) weeks. 65). On 08/13/2021, the gan monitoring all cresults Monday through morning meeting. The any blood sugar result range for MD notificat any Physician's Order reviewed and updated designee will complete diabetic residents acres	(4) weeks, fifty percent of k for two (2) weeks, and dmissions weekly for four (4) the Dietary Manager and/or ing how long it took to pass after arriving at the unit. Il be observed on all three (2) weeks, two (2) meals on of for two (2) weeks, and one (3) units daily for four (4) the DON and/or Designee is knowledge with a verbal and assessment of residents intatory status, identifying perglycemia/hypoglycemia, protocol, documenting a condition, notification of the engiphysician's orders. It is a condition or the engiphysician's orders. It is a condition or the engiphysician's orders. It is a condition or the engiphysician's orders. It is a condition or the engiphysician's orders. It is a condition or the engiphysician's orders. It is a condition or the engiphysician's orders. It is a condition or the engiphysician's orders. It is a condition or the engiphysician's orders. It is a condition or the engiphysician's orders. It is a condition or the engiphysician's orders. It is a condition or the engiphysician's orders. It is a condition or the engiphysician's orders. It is a condition or the engiphysician's orders. It is a condition or the engiphy	{F 6	600}			
	signs and symptoms of hypoglycemia/hypergl						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE ON NURSING HOME LANE PIKEVILLE, KY 41501	<u> </u>	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	staff. Any variance or addressed immediate one (1) week, then fiv (4) weeks. 66). On 08/13/2021, the designee implemente questionnaire on abust residents with wander the proper reporting of units. The employee completed for five (5) then three (3) times a and then weekly for for identified concerns immediately.	tely assessed by licensed identified concerns will be ly. Audits will be daily for e (5) times a week for four the Administrator and/or d an employee se and identification of ring behavior to determine if abuse across all shifts and questionnaire will be staff daily for one (1) week, week for two (2) weeks, our (4) weeks. Any variance will be addressed	{F €	600}			
	Nursing and/or design resident's wandering admission and quarte	risk assessment upon rly with their Minimum Data nt. Any resident identified as cussed in the clinical					·
	interventions. Any var will be addressed imm will be care planned in	riance or identified concerns nediately. New interventions n the morning meeting by g, Assistant Director of					
	of eight (8) or greater the facility and have n witnessed abuse. The review random weekly	esignee will perform residents with a BIMS score to ensure they feel safe in					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		185256					R
NAME OF P	ROVIDER OR SUPPLIER	100200		s	TREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
PARKVIE	W POST-ACUTE AND RE	HABILITATION CENTER		2	00 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)			(X5) COMPLETION DATE
{F 600}	o8/13/2021. Any varia will be addressed imm 69). On 08/25/2021, the conducted audits of reflectronic medical red in the diet/tray card so 70). Beginning on 08/Manager will ensure a kitchen and reaching be conducted for rand one (1) week, twice pland then weekly for outrays arrive at the unit assist in passing trays meal trays, and certification residents promptly. The designee will audit the trays to residents after beginning 09/11/2021 observed on each unit two (2) meals on each weeks, one (1) meal of weeks. 71). The dietary mana admitted/re-admitted beverage preferences admission and enter the system for listing on the completed bi-annually residents. Physician-be audited by the Dieters in the dietary that the completed bi-annually residents. Physician-be audited by the Dieters in the dietary that the completed bi-annually residents. Physician-be audited by the Dieters in the dietary that the completed bi-annually residents.	of unknown origin beginning ance or identified concerns hediately. The Registered Dietician esident diet orders from the cord against orders entered oftware to ensure accuracy. 23/2021, the Dietary and audit meals leaving the the units timely. Audits will flom meals twice daily for er week for two (2) weeks, ne (1) month. Once meal it, management staff will so to ensure residents receive ed nursing assistants assist the Dietary Manager or etime it takes to pass meal or they arrive on the unit. All three (3) meals will be to daily for two (2) weeks, in unit daily for two (2) on each unit daily for four (4) ager or designee will review residents' food and is within 72 hours of them into the diet/tray card their tray cards beginning of food preferences will be and as needed for all ordered snack intakes will lary Manager daily for one our (4) weeks, and monthly	{F 6	600}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF D	ROVIDER OR SUPPLIER	103230	D. W1140	_	TITET 4 DD D D D D D D D D D D D D D D D D D	09/	30/2021
	POST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BE COMPLETIO	
{F 600}	audited beginning on Resources (HR) Direct punches to ensure so their shift. Audits will be through Friday for four Director, and weekendstaff not screened will immediately on the Colon by the HR Director. The ducated on the COV Nurse, an infection codoors will remain lock entry by staff and screentry. 73). Beginning on 09/designee will round so for eight (8) weeks, fiv. (4) weeks to audit infecting shifts and unlobservation of handwand zones; donning/designed.	screenings for staff will be 08/25/2021 by the Human ctor against time clock reening before beginning be completed Monday r (4) weeks by the HR ds audited on Mondays. Any be re-educated OVID-19 Screening Policy he HR Director was ID-19 policy by the Regional control preventionist. All entry led. Visitors must be allowed be staff at the time of 17/2021, the DON and/or leven (7) times each week we (5) times weekly for four lection control compliance on	⟨F 6	600}			
	by the auditor.	II be addressed immediately					
	review all residents or pharmacy to ensure a beginning 09/23/2021	n active script is on file					
	and/or Director of Nur medication pass obse	rse Consultant, Pharmacy, sing will conduct random rvations effective n shifts daily until immediate					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		185256	B. WNG				R 20/2024
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501	[09/	30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E TE	COMPLETION DATE
(F 600)	accuracy of medicatic CMS Critical Element Administration to concobservation of twenty 76). Beginning 09/25/Friday, the DON, ADO audit medication deliving medications daily to eneeding a renewal hapharmacy. Audits will Immediate Jeopardy in 177). Beginning 09/11/and/or DON will be renursing staff daily for adequate staffing is more more more more more more more more	ensure timeliness and ons. The facility utilized the Pathway for Medication duct the medication pass-five medications. 2021 Monday through DN, and/or Designee will very tickets against ordered ensure that all narcotics we been sent to the continue until the s removed. 2021, the Administrator sponsible for monitoring four (4) weeks to ensure naintained. 2021, the Administrator and be responsible for reviewing or four (4) weeks to maintain	{F €	600}			
	09/23/2021 to monitor condition and identific	vill be conducted beginning for residents' change of ation of need for "Stop and ndition) communication.					
	designee performed in BIMS score of eight (a felt safe in the facility	2021, the Administrator or interviews of residents with a B) or greater to ensure they and had not been subjected b. No residents had any					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF 51		163236	D. 111110_			09/	30/2021
	ROVIDER OR SUPPLIER V POST-ACUTE AND RE	HABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 NURSING HOME LANE				
				'	-INCASCEC, NT 41301		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	(X5) COMPLETION DATE
(F 600)	Continued From page	± 152	{F 6	00}			
		will continue to be s by the Administrator or il immediate jeopardy is	`	•			
		gency validated the facility's Immediate Jeopardy on d by :					
	revealed staff assess on 09/11/2021. A revirevealed eight (8) res #324, #45, #14, #357 current pressure ulcer pressure injuries of two comprehensive care p #324, #45, #14, #357 revealed staff updated the resident's current	p-Toe Skin Assessments and all residents in the facility and of the skin assessments addents (Residents #65, and #358) had are with a total number of are with a total number of are total					
	revealed staff assess, pressure ulcers with the with the Regional DO revealed she complet assessment on all resturther revealed that the (20) total pressure injusted facility completed assessments on all recontinued interviews Interdisciplinary Team assessments and Braupdate the residents' Resident #65, #324, # and #358's care plans	sidents on 09/11/2021. She he facility identified twenty uries. She further stated that the Braden Scale esidents on 08/28/2021. revealed the					

STATEMENT OF DEFI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY PLETED
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		185256	B. WING			09/	30/2021
	ST-ACUTE AND RE	HABILITATION CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE ON NURSING HOME LANE PIKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL)			(X5) COMPLETION DATE
with rever reflect addition round the F DON #324 review review each care 2). Reversed Stage deep and a Residual	aled she updated of current pressuration, she completed on 09/15/2021 Registered Dieticial, and the MDS Nat a the MDS Nat a the MDS Nat a the MDS nat a the	e 153 In 09/30/2021 at 1:39 PM I all residents' care plans to re injuries by 09/17/2021. In ed a review of walking I with Therapy Personnel, an, the Medical Director, the lurse for Residents #65, I, #27, #74 and #358. A hterdisciplinary Team Is, current skin breakdown, mented changes as needed. Int #65's medical record Director assessed the end at 1:45 PM and noted a re ulcer on the sacrum; a end in the left and right heels; left inner leg. Review of end care note dated end, revealed the sacrum end (centimeter) (length) by end centimeter) (length) by end centimeter) (length) by end depth with undermining at res 1 cm, muscle exposed. The facility resident's sacral pressure. A review of a wound on 09/15/2021 revealed (6) pressure ulcers, (2) to the left superior calfingth) by 1.4 cm (width) by one (1) to the right hip 2 cm by less than 0.1 cm, preasuring 1.2 cm by 0.8, stage two (2) to left cm by 0.2 cm by less than oright heel measuring 0.6	{F 6	00)			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE	SURVEY PLETED
		185256	B. WNG				R
NAME OF P	ROVIDER OR SUPPLIER	105230	B. WING			09/	30/2021
	W POST-ACUTE AND RE	HABILITATION CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NURSING HOME LANE IKEVILLE, KY 41501		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORRECTION		COMPLETION DATE	
{F 600}	measuring 12 cm by Interventions in place heel protectors while weekly documentation mattress to bed, nutriturning/repositioning. for the sacral pressurd 10:21 AM revealed the by 11 cm by 0.3 cm with drainage and 95 perocessident #65 declined observation of other precord review reveale PM, Physician #1 detweight loss and wound 09/28/2021, Resident in-house wound care record revealed on 05 physician of the declin with no new orders. Twith Failure to Thrive. 3). The facility admitted 09/10/2021, completed 09/10/2021, completed 09/10/2021, and compon 09/10/2021. Resided 09/25/2021 and re-add 09/28/2021. Further revealed staff develop plan on 09/21/2021. Are-admission revealed admission skin assess 09/28/2021, Braden Stateline care plan deceived.	for the resident included in bed, diet as ordered, nof the wound, an air tional supplements, and Observation of wound care elucer on 09/29/2021 at elewound measured 13 cm with a scant amount of ent granulation tissue. If would not consent to the pressure areas. A medical diethat on 09/21/2021 at 2:19 ermined the resident's diethat on 09/21/2021 at 2:19 ermined the resident's diethat on 09/21/2021 at 2:19 ermined the resident's diethat on 09/21/2021 at 2:19 ermined the resident's diethat on 09/21/2021 at 2:19 ermined the resident's wound he resident was diagnosed diethat on 09/21/2021, staff notified the me in the resident was diagnosed ed Resident #355 on diethat a baseline care plan ent #355 was discharged on mitted to the facility on eview of the medical record ped the comprehensive care a review of Resident #355's diethat the resident had an	{F (500}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
		185256	B. WING				R 30/2021
	ROVIDER OR SUPPLIER N POST-ACUTE AND RE	HABILITATION CENTER		200	REET ADDRESS, CITY, STATE, ZIP CODE D NURSING HOME LANE KEVILLE, KY 41501	, <u>oş</u> ,	00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	Resident #309 on 09/Resident #311 on 09/Resident #314 on 09/Resident #320 on 09/revealed the residents well-kempt, and clear residents' beds. Interduring the time of the identified concerns. A for Residents #45, #6 and #320) revealed the Director interviewed thand had no concerns Interview with the ISS revealed she interview #308, #309, #311, #3 with no identified concerns reviews revealed Residents revealed Resident #309, #311, #314, and shower preference and obtained and included review of the resident the comprehensive caplan, revealed staff up to reflect the resident the Vice President of at 4:10 PM revealed s resident preferences, and the faresident's care plan. A interviews revealed the preference was obtain the resident's care plan. A interviews revealed the preference was obtain	n 09/29/2021 at 11:10 AM, 29/2021 at 11:26 AM, 29/2021 at 11:52 AM, 29/2021 at 11:52 AM, 29/2021 at 11:30 AM and 29/2021 at 11:13 AM appeared clean, alinens were on the views with the residents observations revealed no areview of Progress Notes 5, #308, #309, #311, #314, are Interim Social Service the residents on 09/15/2021 with resident hygiene. D on 09/30/2021 at 2:23 PM aved Residents #45, #65, 14, and #320 on 09/15/2021 cerns regarding hygiene. didents during the initial tour 133 PM to 2:32 PM revealed idents #45, #65, #308, dr #320 each had their ad hygiene preference of on their care plan. A service with operations on 09/30/2021 cerns regarding hygiene preference. Interview with Operations on 09/30/2021 cerns regarding hygiene spreference. Interview with Operations on 09/30/2021 cerns regarding hygiene assisted with obtaining She stated each resident nower and hygiene acility updated each a review of resident	{F 6	(000)			